Sedgwick Workers' Compensation Standard Intake Form

Email: SCMSNIC@SedgwickCMS.com Fax: 1-866-261-5795

sedgwick

Client Name:	**Contract Number:**

Reporter Information

First Name:	Last Name:	
Title:	Phone:	Ext:

Location Information

Unit Name:	Unit Number:	
Street Address:		
City:	State:	Zip Code:
Phone Number	Email:	
Is this the Loss Location? Yes ☐ No ☐	Location Code:	

Loss Location (If different from above)

Unit Name:	Unit Number:	
Street Address:		
City:	State:	Zip Code:
Phone Number:		

Claimant Information

Employee ID #:	First Name:	MI:	Last Name:
Home Phone:		Work Phone:	Ext:
Home Address:			
City:	State:		Zip Code:
Email Address:	SSN:		
Date of Birth:	Marital Status: Select One	Gender: Select One	

Claimant Employment Information

Employee Title:	Department:						
Status: Select One							
Full/Part Time: Full Time ☐ Part Time ☐	Date of Hire:	Date of Termination:					
Wage Amount:	Frequency: Select One						
Hours Per Day:	Mon	Tue	Wed	Thur	Fri	Sat	Sun

Claimant Supervisor Information

First Name:	MI:	Last Name:
Title:	Email Address:	
Phone:	Ext:	
Do you question the validity of this claim? Yes ☐ No ☐		

Incident Information

Date of Incident:	Time of Incident:	AM ☐	PM ☐	Date Employer Notified:
Department Where Injury Occurred:				
Incident Description:				
Safeguards/Safety Equipment Provided? Yes ☐ No ☐	Safeguards/Safety Equipment Used? Yes ☐ No ☐			
Cause:				
Body Part:				
Nature:				
Incident Description:				

Medical Information

Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Initial Treatment: Select One	Transportation Type: Select One	
Physician Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	

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Witness Information		
Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Lost Time Information		
Will Claimant Miss Work Beyond Date of Injury? Select One		
Last Date Worked:	Returned to Work Date:	
Salary Continued: Select One		
Contact Information		
First Name:	MI:	Last Name:
Phone:	Ext:	Email Address:
Comments/Remarks:		