

Claim Report Form

Submitted By _____ Title _____ Current Date _____

Employer Name _____ Phone Number _____

Address _____ Employer FEIN Number _____

City _____ State _____ Zip Code _____

EMPLOYEE INFORMATION

First Name _____ Last Name _____ SSN _____

 Male Female Date of Hire _____ Employee Job Title _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Marital Status Single Married Pay Type Hourly SalariedNumber of Dependents _____ Employment Status Full-Time Part-Time

Department _____ Supervisor _____ Employee Phone _____

INJURY INFORMATION

Date of Injury _____ Time of Injury _____ AM PM

Location of Injury (city, state, zip) _____

Date Employee Reported the Injury _____

Time Employee Began Work _____ AM PM Work Shift First Second Third

Description of Accident
(be specific)

Nature of Injury (list all injured body parts, specifying left or right)

Cause of Injury (how the injury or illness occurred)

Type of Medical Treatment Given No Medical Treatment/Precautionary Report First Aid/In-House
 Occupational Health Center/Panel Physician Hospital/ER

Did the employee miss any days of work? Yes No

If the employee did miss work, have they returned to work? Yes No

First date of work missed _____ **Date employee returned to work (or N/A)** _____

Full pay for day of injury? Yes No

TREATMENT INFORMATION

Name of the facility where initial medical treatment was given _____

Treating Physician Name _____ **Address** _____

Phone Number _____ **City** _____ **State** _____ **Zip Code** _____

WITNESS INFORMATION

First Name _____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

INSURANCE INFORMATION

Insurance Carrier Name _____

Insurance Policy Number _____

Policy Period Effective From Date _____ Effective To Date _____

Please complete this form in its entirety and fax or email to:

Toll Free: (724) 864-9265

Internal Use Only

Date Received _____

Time Received _____

Received by _____

Claim Reporting Office
7562 State Route 30
North Huntingdon, PA 15642
Phone (724) 864-8745

“EMPLOYEE” - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION <small>[To be completed by Employee]</small>			
Name (First, Last)		Date of Birth	Social Security Number
Address: (Street, City, State, Zip)			
Phone Number(s): Home: Other:			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Where?		LOCATION:	
Date of Accident	Normal Shift Start Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Worked Until End of Shift <input type="checkbox"/> YES <input type="checkbox"/> NO
Accident was reported to:			
Description of Injury (Describe how the injury occurred, be specific)			
Part (s) of Body Injured: (check <u>all</u> that apply)			
<input type="checkbox"/> Arm	<input type="checkbox"/> Face	<input type="checkbox"/> Groin	<input type="checkbox"/> Internal Organs
<input type="checkbox"/> Back	<input type="checkbox"/> Finger	<input type="checkbox"/> Hand	<input type="checkbox"/> Leg
<input type="checkbox"/> Eye	<input type="checkbox"/> Foot/feet	<input type="checkbox"/> Head	<input type="checkbox"/> Knee
			<input type="checkbox"/> Neck
			<input type="checkbox"/> Elbow
			<input type="checkbox"/> Stomach
			<input type="checkbox"/> Wrist
			<input type="checkbox"/> Shoulder
			<input type="checkbox"/> Other (describe)
Please describe the injured Body Part(s) [i.e. left foot, right thumb]:			
I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true. Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.			
Employee Signature: <small>Original Signature Required.</small>		Date:	

KEYSTONE
7562 State Route 30
North Huntingdon, PA 15642
P-724-864-8745 / F-724-864-9265

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

I hereby authorize and direct you to permit, Keystone, to inspect, examine, make or obtain copies of all information in connection with my injury or illness. This includes, but is not limited to, all records regarding my medical history, consultation, inpatient and outpatient treatment and diagnostic test results, both films and reports.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.)

Patient's Name (Please Print)

Social Security Number

Patient's Signature

Date