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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Instructions:** Complete the claim form and submit it to the agency workers’ compensation service representative for entry to SAP (or the FROI system for independent agencies) and submission to Inservco Insurance Services, Inc., telephone number 800.356.0438. Codes are listed on the reverse side of this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Basic Data:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Report | | | | | Date of Injury | | | | | | | | | Personnel or Soc Sec Number | | | | | | | | | | | Injury Type | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | |  | | | | | | | | | | | Inj Leave Heart&Lung Act 632/534 Other | | | | | | | | | | | | |
| **Employee Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee Last Name | | | | | | | | | | | Employee First Name | | | | | | | | | | M.I. | | | | | Suffix | | | Date of Birth | | | | | | | | Gender |
|  | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | |  | | | | | | | | M F |
| Employee Home Address | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | State | | | | | | Zip + 4 | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | |  | | |
| Residence County | | | | | | | Home Telephone Number | | | | | | | | | | Married | | | Number of Dependents | | | | | | | | Employment Status | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | Y N | | |  | | | | | | | |  | | | | | | | | | |
| **Employer Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency Number | | | Agency Name | | | | | | | | | | | | | | | | Job Classification | | | | | | | | | | | | | | | Date of Hire | | | |
|  | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |
| Org Code | | | Organization Name | | | | | | | | | | | | | | | | Name of Supervisor | | | | | | | | | | | | Work Telephone Number | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | |
| Work Location Address | | | | | | | | | | | | | | | | | City | | | | | | | | | | State | | | Zip + 4 | | | | | | County | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | |  | | | | | |  | |
| **Injury Date Information (enter times as military time):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Time of Injury | | Date of Death | | | | | | | | Date Employer Knew | | | | | | | | | Shift Start Time | | | | | Type of Claim | | | | | | | | | | | | | |
|  | |  | | | | | | | |  | | | | | | | | |  | | | | | Incident Only Medical Only Lost Time > 7 Days | | | | | | | | | | | | | |
| Last Full Day Worked | | | | | | Date Disability Began | | | | | | | | | Date Returned to Work | | | | | | | At Same Wages? | | | | | | | | | | Occur During Overtime? | | | | | |
|  | | | | | |  | | | | | | | | |  | | | | | | | Y N | | | | | | | | | | Y N | | | | | |
| **Injury Description Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injury on Employer Premises? | | | | | | | | | If not in PA, list state | | | | | | | | | If not on premises, list address of accident | | | | | | | | | | | | | | | | | | | |
| Y N | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Cause Code | Cause of injury additional information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injury Type Code 1 | | | | Injury Type Code 2 | | | | | | | | | Type of injury additional information and severity | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Body Part Code 1 | | | | Body Part Code 2 | | | | | | | | | Body part affected additional information (example, left, right, upper, lower, etc.) | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| List all equipment, materials or chemicals employee was using when accident or illness occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe how injury or illness or abnormal health condition occurred. Describe the sequence of events and include any objects or substances directly responsible. Use abbreviations and short statements to include who, what, where, why and how. The what shall be the job assignment the employee was performing when injured. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any tools involved? | | | | | | | | Any mechanical defect? | | | | | | | | Unsafe act? | | | | | | | Unsafe condition? | | | | | | | | | | Amputation? | | | | |
| Y N | | | | | | | | Y N | | | | | | | | Y N | | | | | | | Y N | | | | | | | | | | Y N | | | | |
| Motor vehicle accident? | | | | | | | | Safeguards or safety equipment provided? | | | | | | | | | | | | | | | Safeguards or safety equipment used? | | | | | | | | | | | | | | |
| Y N | | | | | | | | Y N | | | | | | | | | | | | | | | Y N | | | | | | | | | | | | | | |
| **Medical Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Panel of physicians? | | | | Initial treatment | | | | | | | | | | Medical provider name and address | | | | | | | | | | | | | | | | | | | | | | | |
| Y N | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Employer Comments and Signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agree/disagree with description of injury? Other information about injury, including names and telephone numbers of any witnesses. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Supervisor completing form | | | | | | | | | | | | Signature | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |

**Injury Type Codes**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 01 | No Physical Injury | 34 | Hernia | 59 | All Othr Spc Inj NOC | 75 | AIDS |
| 02 | Amputation | 36 | Infection | 60 | Dust Disease, NOC | 76 | VDT-Related Disease |
| 03 | Angina Pectoris | 37 | Inflammation | 61 | Asbestosis | 77 | Mental Stress |
| 04 | Burn | 38 | Adverse Reaction | 62 | Black Lung | 78 | Carpel Tunnel Syndrm |
| 07 | Concussion | 40 | Laceration | 63 | Byssinosis | 79 | Hepatitis C |
| 08 | Hearing Loss | 41 | Myocardial Infarctn | 64 | Silicosis | 80 | Other Cumulative Inj |
| 10 | Contusion | 42 | Poisoning-General | 65 | Rsprtry Dsrdrs | 83 | COVID-19 |
| 13 | Crushing | 43 | Puncture | 66 | Poisn-Chem(non-mtls) | 90 | Mltpl Physical Inj |
| 16 | Dislocation | 46 | Rupture | 67 | Poisoning-Metal | 91 | Mltpl Inj Phys/Psych |
| 19 | Electric Shock | 47 | Severance | 68 | Dermatitis | A1 | Animal Bite |
| 22 | Enucleation/Removal | 49 | Sprain | 69 | Mental Disorder | A2 | Abrasion |
| 25 | Foreign Body | 52 | Strain | 70 | Radiation | A4 | Human Bite |
| 28 | Fracture | 53 | Syncope/Fainting | 71 | Othr Occ Dse Inj NOC | A5 | Insect Bite/Sting |
| 30 | Freezing | 54 | Asphyxiation | 72 | Loss of Hearing | A7 | Lyme Disease |
| 31 | Hearing Loss/Imprmnt | 55 | Vascular | 73 | Contagious Disease | A8 | Stab Wound |
| 32 | Heat Prostration | 58 | Vision Loss | 74 | Cancer | A9 | Gunshot Wound |

**Body Part Codes**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 10 | Multiple Head Injury | 24 | Larynx | 41 | Upr Bck Area(Thrcic) | 55 | Ankle |
| 11 | Skull | 25 | Neck - Soft Tissue | 42 | Lw Bck Area (Lbr&Lbo) | 56 | Foot |
| 12 | Brain | 26 | Trachea | 43 | Back/Disc | 57 | Toe(s) |
| 13 | Ear(s) | 30 | Mltple Upr Extrmtes | 44 | Chest(Ribs&Sft Tsue) | 58 | Great Toe |
| 14 | Eye(s) | 31 | Upr Arm(Clvcl-Scpla) | 45 | Sacrum and Coccyx | 60 | Lungs |
| 15 | Nose | 32 | Elbow | 46 | Pelvis | 61 | Abdomen incl Groin |
| 16 | Teeth | 33 | Lower Arm | 47 | Back - Spinal Cord | 62 | Buttocks |
| 17 | Mouth | 34 | Wrist | 48 | Internal Organs | 63 | Lumbar/Sacral Vertbr |
| 18 | Head - Soft Tissue | 35 | Hand | 49 | Heart | 64 | Artificial Appliance |
| 19 | Facial Bones | 36 | Finger(s) | 50 | Mltple Lwr Extrmtes | 65 | Insf Info 2 Prop Id |
| 20 | Neck - Multiple Inj | 37 | Thumb | 51 | Hip | 66 | No Physical Injury |
| 21 | Vertebrae | 38 | Shoulder | 52 | Upper Leg | 90 | Multiple Body Parts |
| 22 | Neck - Disc | 39 | Wrist(s) and Hand(s) | 53 | Knee | 91 | Bdy Sys/Mtpl Bdy Sys |
| 23 | Neck - Spinal Cord | 40 | Multiple Trunk | 54 | Lower Leg |  |  |

**Cause Codes**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Burn, Heat Or Cold Expos.** | | 15 | Cut/Inj By-Brkn Glas | 57\* | Str/Inj By-Push/Pull | 80\* | Strk-Obj Hndl by Oth |
| 2\* | Burn-Cntct w/ Object | 17 | Cut-Obj Liftd/Handld | 58\* | Strain/Inj By-Reach | 86 | Inj By-Explosion |
| 3\* | Burn-Temp Extremes | **Fall or Slip** | | 60\* | Strain/Inj By-Misc | **Rubbed or Abraided** | |
| 1\* | Burn-Acid Chem | 25\* | Fall/Slip-Diff Level | 54 | Strain/Inj By-Jump | 94\* | Rept Motn |
| 84\* | Electrical Current | 29\* | Fall/Slip-Same Level | 59 | Str/Inj By-Tool/Mach | 95\* | Rub/Abraid-Misc |
| A3\* | Heat Exhaust/Stroke | 33 | Fall/Slip-On Stairs | 61 | Strain/Inj By-Throw | **Miscellaneous** | |
| 4 | Burn-Fire or Flame | 26 | Fall/Slip-Ladder | 97 | Strain-Repitv Motion | A6\* | Human Bite |
| 5 | Burn-Steam/Hot Fluid | 28 | Fal/Slp-Into Opening | 53 | Strain/Inj By-Twist | 90\* | Othr than Phys Caus |
| 11 | Burn-Cold Obj/ Subst | 32 | Fall/Slip-Ice/Snow | **Strike Against or Step On** | | 52\* | Strain/Inj By-Noise |
| 7 | Burn-Welding | 27 | Fall/Slip-Liquid | 70\* | Step On/Strike-Misc | 85\* | Inj By-Anmal/Insct |
| 8 | Burn-Radiation | 30 | Slip-Did Not Fall | 65 | Step/Strik-Machine | 89\* | Misc-Person/Crime |
| 6 | Burn-Dst/Gas/Fms/Vpr | 31 | Fall/Slip-Misc | 66 | Step/Strk-Obj Handld | B1\* | Microbiological Exp |
| 14 | Brn-Abnml Air Presur | **Motor Vehicle** | | 67 | Step/Strik-Scraping | 82\* | Misc-Absorb/Ingest |
| 9 | Burn-Miscellaneous | 50\* | Motr Veh-Misc | 68 | Step/Strk-Statnry Ob | A2\* | Exp Misc Viral Infec |
| **Caught In or Beteween** | | 46 | Motr Veh-Hit Fxd Obj | 69 | Step/Strik-Sharp Obj | A4\* | Exp to Skin Irritant |
| 13\* | Caught In/Betwn-Misc | 45 | Motr Veh-Veh Colison | **Struck By** | | 87\* | Forgn Matter in Eye |
| 10 | Caught In-Machinery | 48 | Motr Veh-Veh Upset | 74\* | Struck-Cowrker/Other | 98 | Misc-Cumulative |
| 12 | Caught In-Obj Handld | 41 | Motr Veh-Train | 75\* | Struck-Fall/Fly Obj | A5 | Gunshot Wound |
| 20 | Caught In-Collapse | 47 | Motr Veh-Airplane | 76\* | Struck-Tool/Machine | A7 | Exposure to TB |
| **Cut, Puncture or Scrape** | | 40 | Motr Veh-Water Veh | 81\* | Sruck/Inj By-Misc | A8 | Exp to Hepatitis B |
| 16\* | Cut/Inj By-Hand Tool | **Strain or Injury By** | | 77 | Struck-Motor Veh | A9 | Exposure to HIV |
| 18\* | Cut/Inj By-Powr Tool | 55\* | Strn/Inj-Hold/Carry | 78 | Struk-Machine In Use | 83 | Pandemic |
| 19\* | Cut/Inj By-Misc | 56\* | Strain/Inj By-Lift | 79 | Struck-Obj Handled | 99 | Misc-Other\*\* |

\* Recommended cause code \*\* Code should rarely be used