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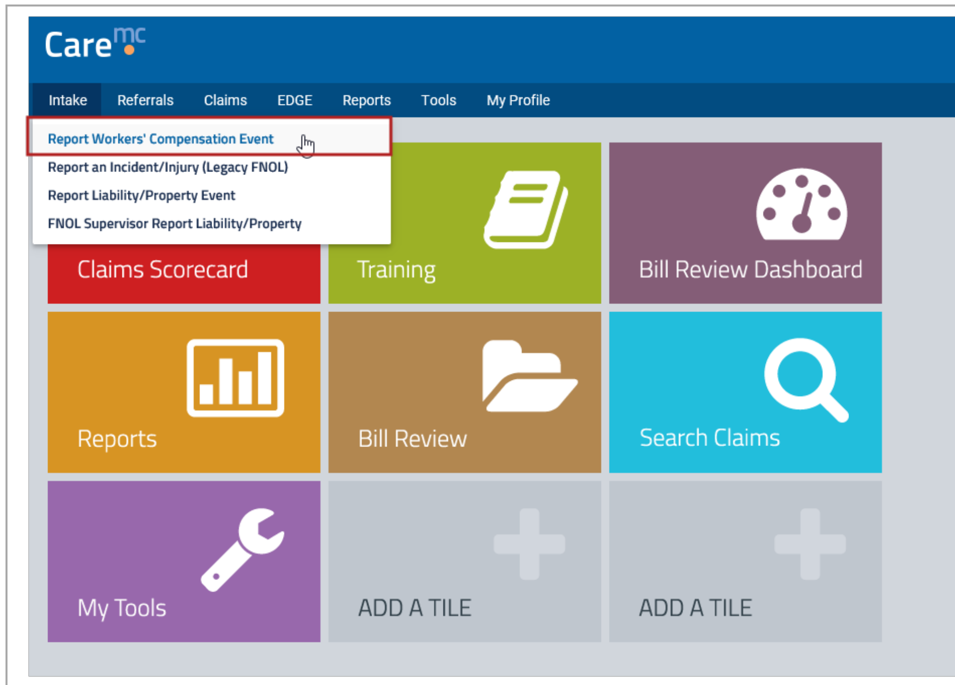
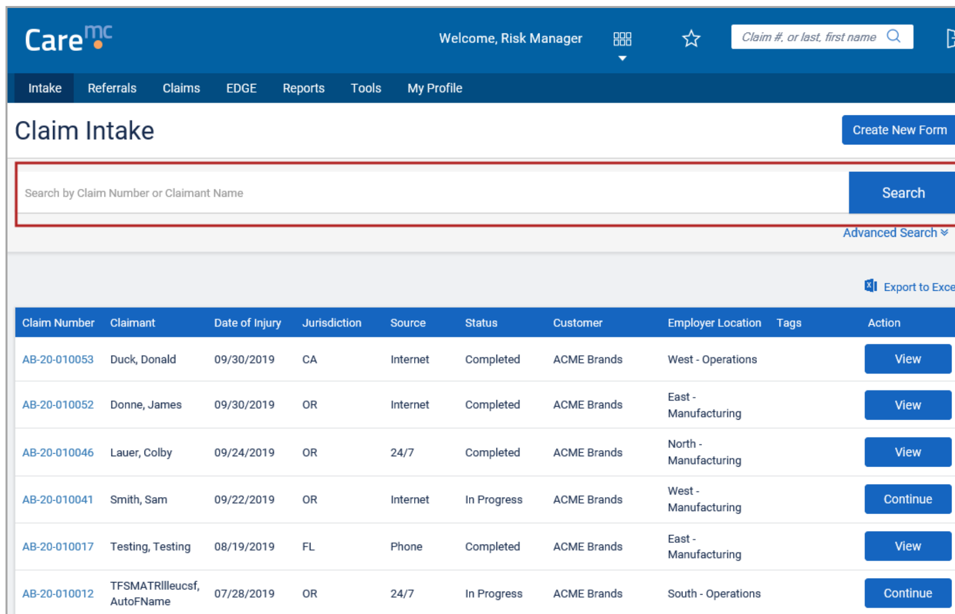
Getting Started

To create a new Intake form, click **Intake** > **Report Workers' Compensation Event**



The Claim Intake screen appears.



Search

When you enter the Claim Intake screen, a list will generate including intake forms New, In Progress and Completed. To narrow the list, you may run a search using the claim number or claimant's name.

If the Search does not narrow the results enough, click on Advanced Search to bring up other filter options you may use.

Advanced Search

Use Advanced Search to search by additional criteria.

From the Claim Intake screen, click **Advanced Search**. The **Advanced Search** screen appears. If you would like FNOLs which were completed through the old FNOL/Intake process, click on the box next to **Include Legacy FNOLs**

and they will be included in the list. These FNOLs are read only and cannot be edited or changed through the new intake process.

Advanced Search Fields

Source	Description
Claim Number	Starts with

Claimant Last Name	Starts with
Claimant First Name	Starts with
Claimant SSN	Full or last four (4)
Date of Birth	Equals
Customer	Pick-list
Source	Pick - list
Status	Pick-list
Jurisdiction	Pick-list
Employer Location	Starts with
Date To Date From	Equals
Date of Injury To	Equals
Created by Last Name	Starts with
Creation Date From	Equals
Creation Date To	Equals

Create a New Claim Intake Form

The Claim Intake screen displays a list of claims currently in process or completed. To report an injury click the **Create New Form**.

The Report an Injury window will open. The boxes containing a red asterisk are required. Any additional information you are able to complete will help speed up the process.
Select the applicable option of Employee or Employer, reflecting whom is entering the report.

Claim Intake

Save as Draft

Customer: **ACME Brands** Claimant: --- Claim Number: ---

- Report an Injury
- Employer
- Incident
- Details
- Review & Submit

Report an Injury

Who is reporting? * ○ Employee ◉ Employer

Your First Name * Risk

Your Last Name * Manager

If the name and phone number is not yours correct the information. Indicate if you are the supervisor by selecting **Yes** or **No**.

Claim Intake

Save as Draft

Customer: **ACME Brands** Claimant: --- Claim Number: ---

- Report an Injury
- Employer
- Incident
- Details
- Review & Submit

Report an Injury

Who is reporting? * ○ Employee ◉ Employer

Your First Name * Risk

Your Last Name * Manager

Your Callback Number * ( )- -

Your Email

Are you the employee's supervisor? * ○ Yes ○ No

Injured Employee

Provide the injured employee's information in the boxes provided. In order to move forward, the boxes with a red asterisk must be completed.

Injured Employee

First Name * Mickey

Middle M

Last Name * Mouse

Employee ID Number 762934568

Date of Birth 11/18/1928

Social Security Number ***-**-1928

SSN is unknown

Date of Injury 09/30/2019

Search

If the Social Security Number is unknown **click** the box next to **SSN is unknown**.

When the SSN is unknown is checked the SSN in the claim profile screen will show SSN Needed as a reminder to update the social security number when obtained.

Claim Details - Herbert, George: AB-19-010059 [EC]

Incident/Injury | Contacts | Medical | Financial | Documents/Notes | Legal | Services | Reference | New Service Referral | All

Claim Type	Workers' Compensation			Flags	
Status	Active	Date of Incident	01/20/2019	Employer	East - Manufacturing
Multiple Claims	Yes	Date of Hire		Customer	ACME Brands
SSN	SSN Needed	Marital Status		Adjuster	
Date of Birth	02/15/1980	Jurisdiction State	OR	Jurisdiction Claim No	
Gender	Male	Policy Effective Date		Policy Term Date	Policy

When all known information is input click **Search.** Care^mc system searches for duplicate claims and the form automatically saves as a Draft.

Until the form is completed, the system will automatically save as a draft while the form is in process. You are also able to click on **Save as Draft** to manually save the information.

Employer

Confirm the Customer information is correct. If not, choose the correct Customer from the list.

Enter any other known information to narrow the results of the Employer Search. Once all known information is input, click **Search**. Depending on the information provided the results will show levels of locations for the Customer chosen.

Review the location choices and click **Select** for the location applicable for the claim. Care[mc] provides a message asking for verification the selected location is accurate. Click **OK** to proceed.

Incident

Using the drop down menus, complete the questions with all known information.

The following will provide definitions of the **Severity of Injury** to help you choose the correct severity level:

Severity	Type of Care
Severe	Any or none

Severity	Type of Care
Moderate	None Emergency Hospitalized < 24hrs Hospitalized Overnight Inpatient Initial/Major Medical
Minor	Emergency Hospitalized < 24hrs Hospitalized Overnight Inpatient Initial/Major Medical
Any	**Fatality**

When all the questions are complete Click **Check for Duplicates**

Customer: ACME Brands Claimant: Mouse, Mickey M Claim Number: --- Save as Draft

Report an Injury
Employer
Incident
Details
Review & Submit

Accident State * CA - California

In order to determine the proper Jurisdiction, please select from the following:

Hire State * CT - Connecticut
Primary Work State * CA - California

Jurisdiction: CA - California

When did the incident happen?

Date of Injury * 09/30/2019

Who was injured?

First Name * Mickey
Middle M
Last Name * Mouse
Employee ID Number 762934568
Date of Birth 11/18/1928
Social Security Number ***-**-1928
SSN is unknown

Check for Duplicates

Previous

If the system does not find any duplicates, the following message displays:

No matches found based on criteria. Please add/revise criteria or continue to Employer Location Search.

If duplicates are found, a screen displays the possible matching claims:

From this screen, you can click:
View - takes you to the details of the possible duplicate. The claim displays as read-only.

Select - if you want to continue the intake process on the chosen incident. The current intake process will stop and will be automatically archived.

A confirmation screen appears and indicates the new form will be archived and the existing intake claim will be selected. Click **Yes**.

To continue to work on the current intake, click **Ignore & Continue**.

Details

Employee / Claimant

Now the Intake form is ready to enter the employee/claimant information.

Customer: **ACME Brands** Claimant: **Mouse, Mickey M** Claim Number: **AB-20-010055**

- Incident Summary
- Details
  - **Employee**
  - Occurrence
  - State Specific
  - Customer Specific
  - Documents
- Review & Submit

Employee / Claimant

Employee Information

First Name * Mickey
Middle M
Last Name * Mouse
Suffix
Employee ID Number 762934568
Date of Birth 11/18/1928
Email Address
Social Security Number * ***-**-1928
SSN is unknown
Hire Date mm/dd/yyyy
Hire State * CT - Connecticut
Gender * Male
Marital Status
State Where Payroll Taxes are Filed

Required fields are marked by a red asterisk *

Using the **Drop Down Menu** to make a selection appropriate to the Employee's information. Select the **Body Part** and **Body Part Side** and click on **Add Body Part**. All intake reports must have at least one body part listed. Up to 14 body parts made be added during the intake process. Once all information is provided Click **Next.**

Address *
123 Main Street

Suite, Apt., Box

City *
Hollywood

State *
CA - California

Zip *
12345

Zip + 4

Home Phone *
(443)-555-1212

Employment Related Information

Occupation/Job *
Operator

Alternative Phone Type

Alternative Phone
( )- -

Ext

Employment Status
Regular/Full-Time Employee

Hours Per Day Worked
10

Days Per Week Worked
5

Work Week Type
Standard

Wage Amount
$200.00

Wage Period
Weekly

Full pay for the date of injury? Yes No

Body Parts

Body Part

Body Part Side

Add Body Part

Body Part	Body Part Side
Hand	Right

Previous

Next

Occurrence

Enter information about the injury.

Required fields are marked by a red asterisk *

Using the **Drop Down Menus**, select the appropriate options reflecting the information about the occurrence.

Incident Summary
Details
Employee
Occurrence
State Specific
Customer Specific
Documents
Review & Submit

Accident Information

Intake Source *
Internet

Location Name

Street Address

Suite

City

State *
CA - California

Zip

Zip + 4

County

Accident Location Desc.

Once all information is provided Click **Next**.

Description of Accident *
Was setting down heavy box, crushed thumb beneath it.

Additional Details

Were safeguards provided? Yes No Unknown

Were safeguards used? Yes No Unknown

Did Accident Occur on Employer Premises? Yes No Unknown

Previous Next

State Specific

The next screen to appear is the State Specific screen. If the jurisdiction requires specific information you will enter that information here. If there is no required information click **Next**.

State Specific

The following Claim Intake questions are requested by Oregon.

# of Dependents

Previous Next

Customer Specific

The next screen to appear is the Customer Specific screen. If the customer requires anything specific, the information will be requested and input here. Once complete, or if there are no customer specific requirements, click **Next**.

Customer Specific

The following Claim Intake questions are requested by ACME Brands.

Employee Identification Number

Previous Next

Enter the information and click **Next**.

Contacts

All of the previously entered contact information is provided in this view. Additional contacts may also be entered by clicking **Add Contact.**

Contacts

Add Contact

Priority	Contact Type	Name	Communication Preference
Main	Claimant Supervisor	ff, dd	Work Phone

Previous Next

Add Contact

Contact Information

At least Company Name or First and Last Name are required.

Contact Type
Contact Type is required.
Company Name
Job Title
Priority
Main
Prefix
First Name
Middle Name
Last Name
Suffix

Contact Location

Address Line 1
Address Line 2
City
State
Zip Code
Zip Code Ext

Contact Communication

At least one communication is required.

Communication Preference
Work Phone
Work Phone Ext
Cell Phone
Home Phone
Fax
Email

Confirm Cancel

Select the **Contact Type** from the drop down menu.

Providing either a **Company Name** or **First and Last Name** of the contact are required.

Provide any **Address** information you have on the contact.

Contact Location

Address Line 1 | Address Line 2

City | State | Zip Code | Zip Code Ext

A communication preference is required. Select one option for the **Communication Preference** drop down menu. Additional phone, fax and e-mail information may also be provided in the Contact Communication section.

Contact Communication

At least one communication is required.

Communication Preference: Email | Work Phone: ( )- - | Work Phone Ext | Cell Phone: ( )- -

Home Phone: ( )- - | Fax: ( )- - | Email

Once all known contact information is complete, click **Confirm** to return to the **Contacts** list.

Contact Communication

Communication Preference: Email | Work Phone: (503)-555-1212 | Work Phone Ext | Cell Phone: ( )- -

Home Phone: ( )- - | Fax: (503)-555-1213 | Email: williamm@smithlyons.com

Confirm | Cancel

At this point, you may continue to add another contact or click **Next** to move forward in the intake completion process.

Contacts

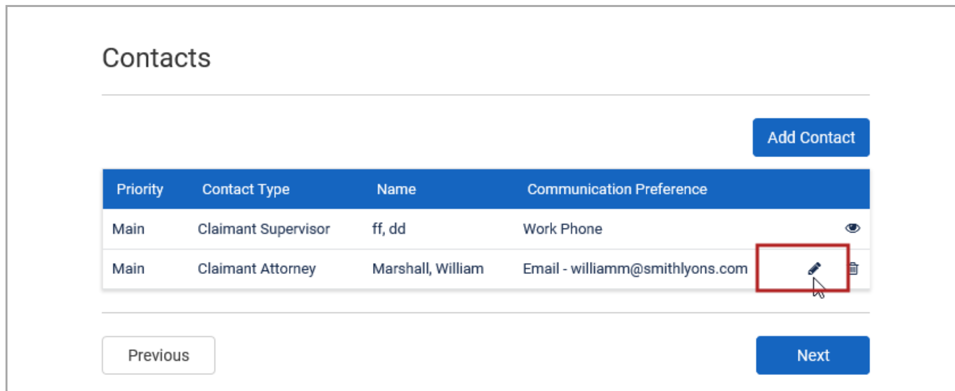
Add Contact

Priority	Contact Type	Name	Communication Preference
Main	Claimant Supervisor	ff, dd	Work Phone
Main	Claimant Attorney	Marshall, William	Email - williamm@smithlyons.com

Previous | Next

Edit a Contact

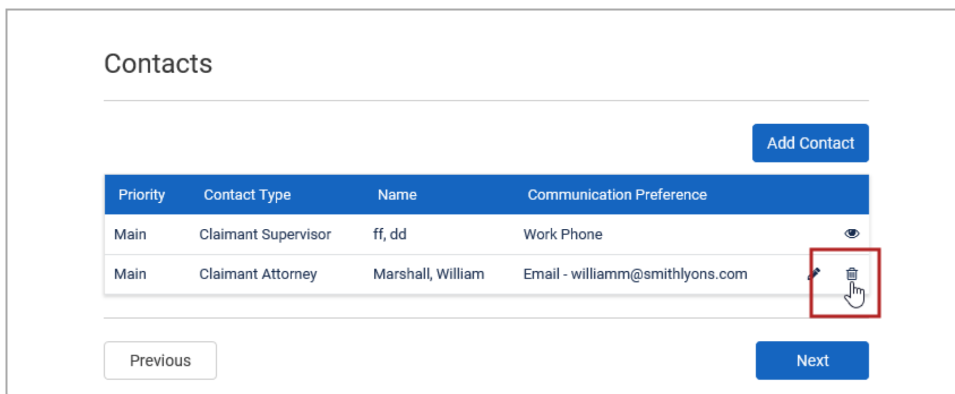
If a contact is manually added to the intake it may be edited through the intake process. Click on the **Edit icon**.



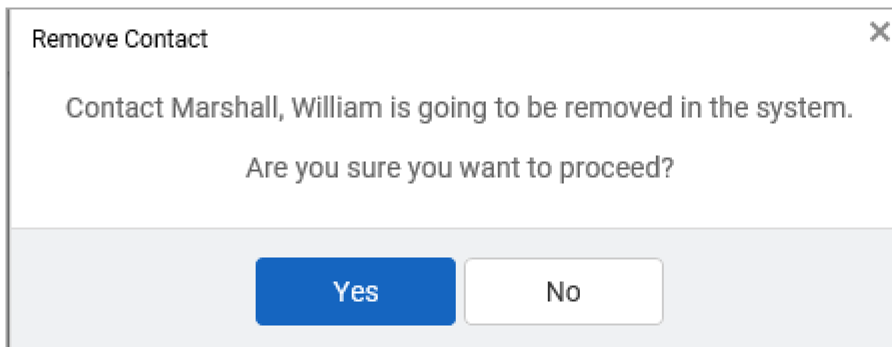
This opens the contact information in an edit mode and additional information or correcting existing information may be completed. Once Complete click **Confirm** to save changes.

Delete a Contact

If a contact is manually input the contact may be deleted from the Contacts list during the intake process. To delete the contact click the Delete icon.



The system will ask you to confirm you wish to remove the contact from the system. Click **Yes** to delete the contact.



Review & Submit

The last step in the **Detail** section is **Documents**. This is not yet active. When it becomes active, it will allow documents to be uploaded to the intake process. Those documents will be uploaded to the claim upon it's creation.

For now, after clicking next on the **Customer Specific** page will bring you to the **Review & Submit** window.

Click + in each section to review the information. When you are through, click **Acknowledge & Submit**. There is a check for duplicates.

When your form is successfully submitted, you will see a confirmation screen:

Initial Treatment Guide

The Initial Treatment Guide is comprised of a Treatment Authorization, Pharmacy Guide and a Physician's Report page. A copy of the Initial Treatment Guide may be generated as a PDFand printed or sent to recipients via e-mail or fax.

Pharmacy Guide

Recipient: Fill out the form and Click Submit to Email or Fax the Initial Treatment Guide to the recipient of your choice.

Initial Treatment Provider/Facility: Includes a provider location map and Call to Schedule Appointment: info space.

Recipient

First Name *

Last Name *

Fax

Email

Submit

Treatment Authorization Form

Treatment Authorization | Pharmacy Guide

Temporary Pharmacy Card: Enables the Injured Worker to quickly fill a prescription. Card is only valid for the First Fill Only.

Physician's Report

Physician's Report includes:

- Physician and Patient Information
- Diagnosis
- Restrictions
- Return to Work, MMI and Next Appointment dates

- Ancillary Services contact info

When you are finished with the Initial Treatment Guide form, click **Submit**.

Additional access to the Initial Treatment Guide

Once the Initial Treatment Guide has been created, you can access it from:

- Intake Submittal Success screen

Claim Intake

Initial Treatment Guide

Customer: **ACME Brands** Claimant: **Fairbanks, Anna** Claim Number: **AB-19-010079**

Success!

Status: Processing claim...

Your form has been submitted.

Claimant:	Fairbanks, Anna
Claim Number:	AB-19-010079
Date Received:	02/05/2019

Special Instructions

Special Instructions are coming soon!

- From the Intake list, click View on the claim intake.

Claim Intake

Create New Form

Search by Claim Number or Claimant Name

fairbanks

Search

Advanced Search

Export to Excel

Claim Number	Claimant	Date of Injury	Jurisdiction	Source	Status	Customer	Employer Location	Action
AB-19-010079	Fairbanks, Anna	02/03/2019	OR	Phone	Completed	ACME Brands	East - Manufacturing	View

Rows per page: 10 1 - 1 of 1

- Click Initial Treatment Guide.

Claim Intake

Initial Treatment Guide

Customer: **ACME Brands** Claimant: **Fairbanks, Anna** Claim Number: **AB-19-010079**

Status: Completed

View Intake

1. Employer +

2. Contact +

3. Claimant +

4. Incident +

5. Other Details +

Payroll Feed

If a customer currently has a payroll feed set up with CorVel, Employee and Employer information automatically populates.

Report an Injury

Source *
Mail

Contact First Name
Ima

Contact Last Name
Supervisor

Contact Callback Number
503-555-1212

Contact Email
Ima_Supervisor@Acme.com

Injured Employee

First Name *
John

Middle

Last Name *
Smith

Employee ID Number

Date of Birth
mm/dd/yyyy

Social Security Number
- -

SSN is unknown

Date of Injury
mm/dd/yyyy

Search

Name	SSN	DOB	EEID#	City/State	Customer	Action
john Smith	***-**-1122	04/22	00000000	Portland, OR	Acme	Select

If you cannot find the employee, please continue to Employer Location Search.

Next

1. Select **Next**.

Claim Intake

Discard | Save as Draft

Customer: N/A Claimant: Martinez, Daniel Claim Number: N/A

- Report an Injury
- Employer
- Incident
- Details
- Review & Submit

Customer: Search for or select a Customer

Location | TPA

Address | City | State | Zip

Clear All | Clear Location | Search

When a payroll feed finds the employee and the SSN is a match, you click **Select** to choose that employee. If the employee is not on the list, click **Next** without selecting anything to move to the **Employer Location** search.

Report an Injury

Source * : Mail

Contact First Name: Ima

Contact Last Name: Supervisor

Contact Callback Number: 503-555-1212

Contact Email: Ima_Supervisor@Acme.com

Injured Employee

First Name * : John

Middle

Last Name * : Smith

Employee ID Number

Date of Birth: mm/dd/yyyy

Social Security Number: - -

SSN is unknown

Date of Injury: mm/dd/yyyy

Search

Name	SSN	DOB	EEID#	City/State	Customer	Action
john Smith	***-**-1122	04/22	00000000	Portland, OR	Acme	Select

If you cannot find the employee, please continue to Employer Location Search.

Next

Glossary

M

My Term

My definition