Sedgwick Workers' Compensation Standard Intake Form

Telephonic Intake – 800.416.3020 Fax – 866.261.5795
Email – scmsnic@sedgwickcms.com

sedgwick

WC CLAIMS SHOULD BE REPORTED IMMEDIATELY

***Client Name: S&P Global**	***Contract Number: 2097**

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:				

Medical Information

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

Sedgwick Workers' Compensation Standard Intake Form

Telephonic Intake – 800.416.3020 Fax – 866.261.5795
Email – scmsnic@sedgwickcms.com

City:	State:	Zip Code:
Phone:	Ext:	
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:		

*Indicates a mandatory field that must be completed in order accept a claim. However, in order to best process your request, please provide as much information as possible.