



MASSACHUSETTS BAY SELF-INSURANCE GROUP, INC.

AIM (Accident and Injury Management) Form

EMPLOYEE INJURY REPORT

1. This portion to be completed by employer:

ACCIDENT INFORMATION	Employer Name:	Phone:	Fax:
	Employee Name:	D.O.B:	
	Home Address:		
	Home Phone:	Job Title:	Date of Hire:
	Social Security #:	Supervisor:	Location Code:
	Date of Accident:	Accident Location	
	Cause of Accident:		
	Description of Accident:		
	What Area of Body Was Injured?		
	Names of Witnesses:		Date Injury Reported:
	Has Employee Lost Time from Work?	1st Day:	5 <sup>th</sup> Day:
	Has Employee Returned to Work?	Date Returned to Work:	
	Has Medical Treatment Been Sought?	Date of 1 <sup>st</sup> Treatment?	
	Name and Address of Medical Provider:		
		Provider Phone:	Is Light Duty Available?
	Diagnosis:		
Treatment Plan:			
Employer Signature:		Date:	

This form must be sent to MBSIG within 24 hours of the incident.

If the employee has lost more than five calendar days from work, please send original Form 101 to DIA, and send a copy to MBSIG.

2. This portion to be completed by Medical Provider and returned to employer:

DOCTORS REPORT OF TREATMENT	Medical Provider Name:	Date of Service:
	Address:	
	Phone:	Fax:
	Diagnosis:	
	Treatment Plan (Please include the frequency and duration of treatment.):	
	Next appointment (date and time):	

MEDICAL RELEASE AUTHORIZATION

I hereby authorize any hospital / clinic, physician, Nurse Practitioner, Physician Assistant, chiropractor, or any other person / provider who has attended to / treated me to furnished / release any and all information and facts regarding my injury / illness due to the above workers' compensation claim, including reports and records, results of diagnostic tests, diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment, to representatives of the Massachusetts Bay Self-Insurance Group. I also authorize the release of Utilization Review information / determinations regarding my injury / illness due to the above workers' compensation claim, to the Massachusetts Bay Self-Insurance Group Medical Case Consultant / Nurse Case Manager.

This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on the above noted date of injury and for no other purpose, now or in the future. I agree that a photocopy of this authorization shall be as valid as the original.

Date: \_\_\_\_\_

Employee signature: \_\_\_\_\_

Please Print Employee Name: \_\_\_\_\_

Please fax this form to: Massachusetts Bay Self-Insurance Group, Inc. (FAX 781-376-9907)
or mail to: Massachusetts Bay Self-Insurance Group, Inc., 15 Cabot Road, Woburn, MA 01801 (Tel. 800-222-5963)
or email to: claims@cabotrisk.com