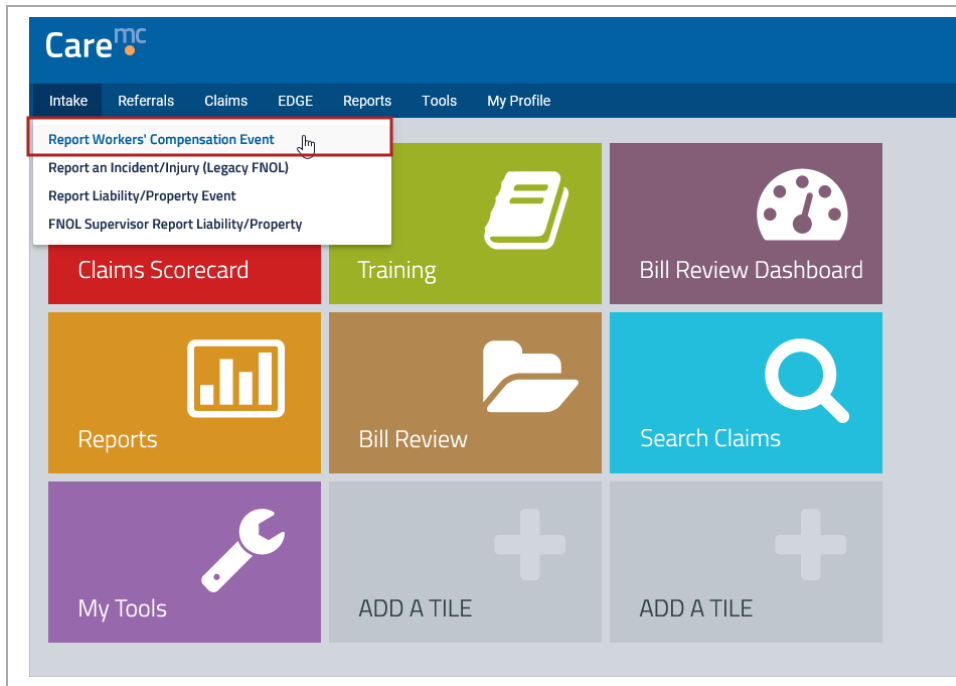

TOC

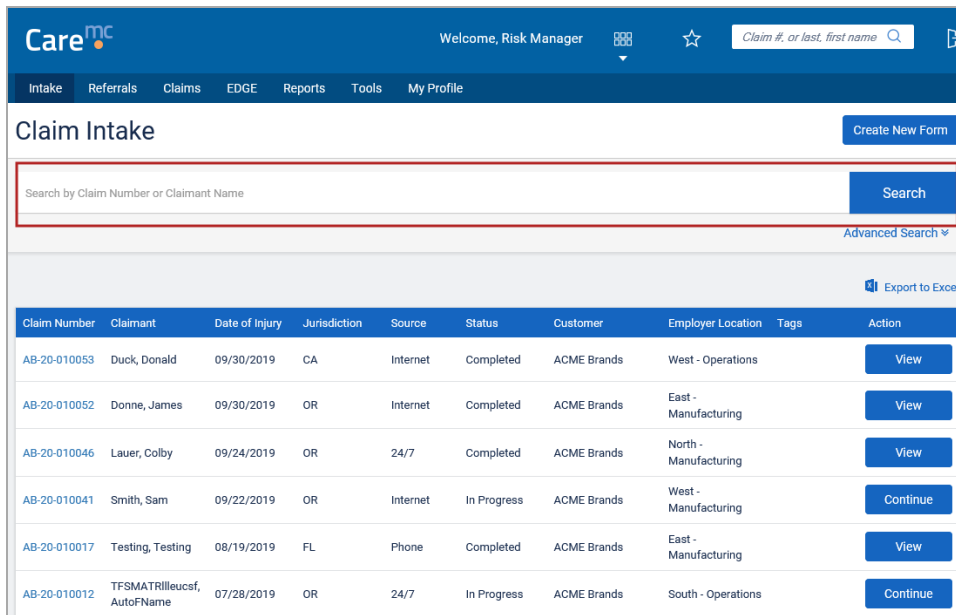
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Getting Started

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 screenshot shows the 'Claim Intake' interface. At the top, there is a navigation bar with links for Intake, Referrals, Claims, EDGE, Reports, Tools, and My Profile. Below the navigation bar, the title 'Claim Intake' is displayed. A search bar is present with the placeholder text 'Search by Claim Number or Claimant Name' and a 'Search' button. To the right of the search bar is a 'Create New Form' button, which is highlighted by a large red arrow. Below the search bar, there is an 'Advanced Search' link and an 'Export to Excel' button. The main content area displays a table of claims with the following columns: Claim Number, Claimant, Date of Injury, Jurisdiction, Source, Status, Customer, Employer Location, Tags, and Action. The table contains four rows of data, each with a corresponding 'View' or 'Continue' button in the Action column.

Claim Number	Claimant	Date of Injury	Jurisdiction	Source	Status	Customer	Employer Location	Tags	Action
AB-20-010046	Lauer, Colby	09/24/2019	OR	24/7	Completed	ACME Brands	North - Manufacturing		View
AB-20-010041	Smith, Sam	09/22/2019	OR	Internet	In Progress	ACME Brands	West - Manufacturing		Continue
AB-20-010017	Testing, Testing	08/19/2019	FL	Phone	Completed	ACME Brands	East - Manufacturing		View
AB-20-010012	TFSMATRilleucsf,	07/28/2019	OR	24/7	In Progress	ACME Brands	South - Operations		Continue

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.

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

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

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.

Claim Number: ---

Report an Injury

Who is reporting? *

Employee Employer

Your First Name * Your Last Name *

Save as Draft

Employer

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

Claim Intake **Save as Draft**

Customer: ACME Brands Claimant: Mouse, Minnie Claim Number: ---

Report an Injury
 Employer
 Incident
 Details
 Review & Submit

Customer: ACME Brands

Location: TPA:

Address: City: State: Zip:

Clear All Clear Location Search

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.

Claim Intake **Save as Dra**

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

Report an Injury
 Employer
 Incident
 Details
 Review & Submit

Customer: ACME Brands

Location: TPA:

Address: City: State: CA - California Zip:

Clear All Clear Location Search

Your search returned 1 location(s).

Location	Address	City	State	Zip	TPA	Action
ACME Brands (1 of 2 Shown)						
Acme Brands (1 of 2 Shown)						
Region 2 (1 of 2 Shown)						
South West (1 of 2 Shown)						
West (1 of 3 Shown)						
West - Operations	2010 Main St.	Irvine	CA	926...	CorVel Enterprise Comp	Select

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.

Claim Intake Save as Draft

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

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

Customer: ACME Brands

Location: TPA:

Address: City: State: CA - California Zip:

Clear All Clear Location Search

Your search returned 1 location(s).

ACME Brands > Acme Brands > Region 2 > South

Location

West (1 of 3 shown)

West - Operations 2010 Main St. Irvine CA 926... CorVel Enterprise Comp Select

Message from webpage

The selected employer is West - Operations, 2010 Main St, ACME Brands

OK Cancel

Incident

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

Claim Intake Save as Draft

Customer: **ACME Brands** Claimant: **Smith, Thomas** Claim Number: ---

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

Incident

What is the severity of the injury?

Severity *

- Minor
- Moderate
- Severe

Type of Care

Where did the incident happen?

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 * Primary Work State *
CT - Connecticut CA - California

Jurisdiction: CA - California

When did the incident happen?
Date of Injury *
09/30/2019

Who was injured?

First Name * Middle Last Name *
Mickey M Mouse

Employee ID Number Date of Birth
762934568 11/18/1928

Social Security Number SSN is unknown
***-**-1928

[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:

Duplicate Check X

Current Intake Information

Claim Number:	AB-20-010057	Claimant:	Mouse, Mickey	SSN:	1928
Date of Birth:	11/18/1928	Employee ID:	762934568	Home State:	—
Date of Injury:	09/30/2019	Primary Body Part:	—	Customer:	ACME Brands
Source:	Internet	Modified By:	Manager, Risk	Modified Date:	10/02/2019
Status:	In Progress				

Does a report below match the same incident / injury you are reporting? If so, click "Select" on the matching entry to discard the current intake, otherwise click the "Ignore & Continue" button.

Claim Number	Claimant Name	DOI	Primary Body Part	State	Source	Status	Action
AB-20-010055	Mouse, Mickey	09/30/2019	Thumb	CA	Internet	Completed	<div style="border: 1px solid red; display: inline-block; padding: 2px;">View</div> <div style="border: 1px solid red; display: inline-block; padding: 2px; margin-left: 5px;">Select</div>

Ignore & Continue
Close

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**.

Confirm Action X

The following claim intake is going to be discarded and archived in the system:

Claim Number: **AB-20-010057**

Claimant: **Mouse, Mickey**

Date of Injury: **09/30/2019**

You are about to proceed with the claim intake that you selected in the matching grid:

Claim Number: **AB-20-010055**

Claimant: **Mouse, Mickey**

Date of Injury: **09/30/2019**

Are you sure you want to proceed?

Yes
No

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

<input type="text" value="First Name *"/> Mickey	<input type="text" value="Middle"/> M	<input type="text" value="Last Name *"/> Mouse
<input type="text" value="Suffix"/>	<input type="text" value="Employee ID Number"/> 762934568	
<input type="text" value="Date of Birth"/> 11/18/1928	<input type="text" value="Email Address"/>	
<input type="text" value="Social Security Number *"/> **-**-1928	<input type="checkbox"/> SSN is unknown	
<input type="text" value="Hire Date"/> mm/dd/yyyy	<input type="text" value="Hire State *"/> CT - Connecticut	
<input type="text" value="Gender *"/> Male	<input type="text" value="Marital Status"/>	
<input type="text" value="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

City *
Hollywood

Zip *
12345

Suite, Apt., Box

State *
CA - California

Home Phone *
(443)-555-1212

Employment Related Information

Occupation/Job *
Operator

Alternative Phone Type
Alternative Phone
() - -

Employment Status
Regular/Full-Time Employee

Days Per Week Worked
5

Wage Amount
\$200.00

Alternative Phone
Ext

Hours Per Day Worked
10

Work Week Type
Standard

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.

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

Occurrence

Occurrence Information

Date of Injury * 09/30/2019	Time of Injury * 12:00 AM	Time Zone PT
Date Employer Notified * 09/30/2019	Date Admin Notified 09/30/2019	
Nature of Injury Crushing		
NCCI Cause of Injury Struck or Injured By MATERIAL HANDLING		
Date Last Worked 09/30/2019	Date Disability Began 09/30/2019	
Return to Work Date 09/30/2019	Return To Work Type Restricted - Full	

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

Care/Treatment Information

Severity Of Injury * Moderate	
Death Result of Injury?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Salary Continued?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Report Only? * <i>i</i>	<input type="radio"/> Yes <input checked="" type="radio"/> No
Questioning Validity of Injury? *	<input type="radio"/> Yes <input checked="" type="radio"/> No
Type of Care Clinic	
Seeking Medical Treatment? *	<input checked="" type="radio"/> Yes <input type="radio"/> No
Was Employee Hospitalized? *	<input type="radio"/> Yes <input checked="" type="radio"/> No

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

Accident Information

Intake Source *

Location Name

Street Address

Suite

City

State *

Zip

Zip + 4

County

Accident Location Desc.

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

Description of Accident *

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.

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

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

Add Contact

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

Contact Type Company Name Job Title

Priority

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

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

Add Contact

Contact Information

Contact Type | Company Name

Carrier

Case Manager

Claimant Attorney

Claimant Emergency Contact

Claimant Supervisor

Claimant's Contact

Claims Manager

Client - Alternate Contact

Middle Name

Contact Location

Address Line 1

City

State

Contact Communication

Communication Preference

Work Phone () - -

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

Contact Information

Contact Type
Claimant Supervisor

Company Name

Job Title

Priority
Main

Prefix

First Name
Josh

Middle Name

Last Name
Grobin

Suffix

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

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

Work Phone (503)-555-1212 Work Phone Ext Cell Phone () - -

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

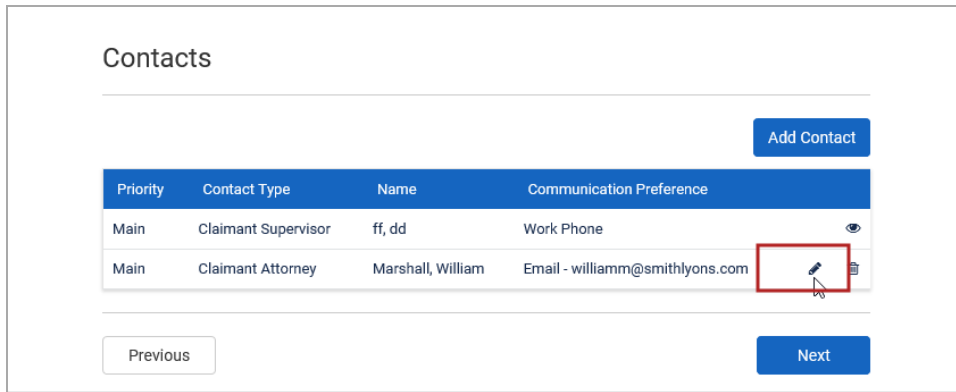
At this point, you may continue to add another contact or click **Next** to move forward in the intake completion process.

Contacts

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

Edit a Contact

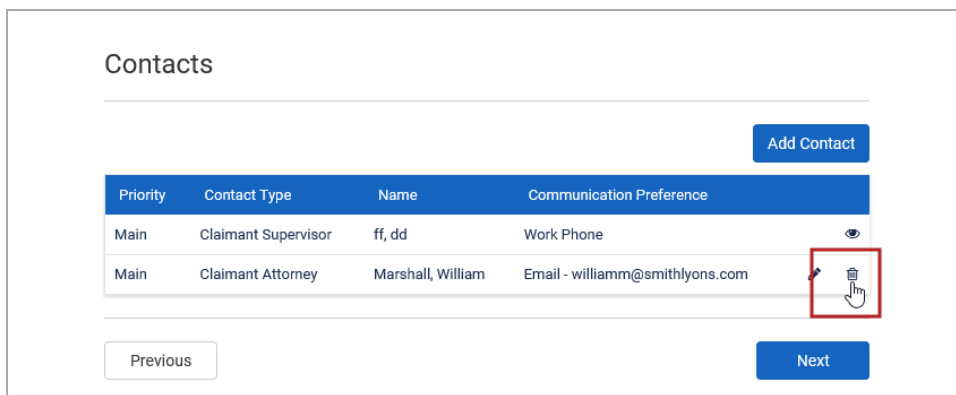
If a contact is manually added to the intake it may be edited through the intake process. Click on the **Edit** icon.



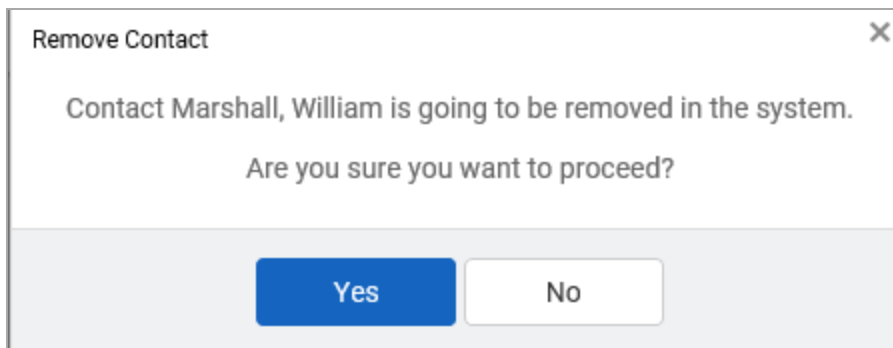
This opens the contact information in an edit mode and additional information or correcting existing information may be completed. Once Complete click **Confirm** to save changes.

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.

The screenshot shows the 'Claim Intake' interface. At the top right, there are 'Discard' and 'Save as Draft' buttons. Below the header, the customer information is displayed: 'Customer: ACME Brands', 'Claimant: Fairbanks, Sean', and 'Claim Number: AB-19-010064'. On the left, a sidebar menu lists several sections: 'Incident Summary' (checked), 'Details' (selected), 'Employee' (checked), 'Occurrence' (checked), 'State Specific' (checked), 'Customer Specific' (checked), 'Documents' (unchecked), and 'Review & Submit' (checked). The main content area is titled 'Review & Submit' and contains a blue instruction box: 'Please review the information concerning this injury/accident. Please select Acknowledge & Submit to confirm the reported information is accurate.' Below this are five expandable sections: '1. Employer', '2. Contact', '3. Claimant', '4. Incident', and '5. Other Details', each with a green checkmark and a '+' icon. At the bottom, there are 'Previous' and 'Acknowledge & Submit' buttons.

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:

The screenshot shows the 'Claim Intake' success confirmation screen. At the top right, there is an 'Initial Treatment Guide' button. Below the header, the customer information is displayed: 'Customer: ACME Brands', 'Claimant: Fairbanks, Sean', and 'Claim Number: AB-19-010064'. The main content area is titled 'Success!' and features a green message box: 'Your form has been submitted.' To the right, the status is 'Processing claim...'. Below this, there is a table with the following information: 'Claimant: Fairbanks, Sean', 'Claim Number: AB-19-010064', and 'Date Received: 02/02/2019'. At the bottom, there is a section titled 'Special Instructions' with a blue message box: 'Special Instructions are coming soon!'.

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 PDF and 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 *	<input type="text"/>
Last Name *	<input type="text"/>
Fax	<input type="text"/>
Email	<input type="text"/>

Submit

Treatment Authorization Form

CORVEL Treatment Authorization | Pharmacy Guide

EMPLOYER: Give both pages of this document to the injured employee to provide to the authorized treating physician.
Employer/Company: East - Manufacturing

EMPLOYEE: The following provider/facility was selected from CorVel's provider network. It is your responsibility to contact the provider to schedule an appointment and to confirm the location.
Employee name: Frank Heffley Record ID: AB-12-010029
Date of Injury: 3/14/2012 Treating physician/facility: Jerry E Nye

INITIAL TREATMENT PROVIDER/FACILITY:
Provider/Facility Name: Jerry E Nye
Address: 2222 NW Lovejoy St Ste 401, Portland, OR 97210
Call to schedule an appointment (503) 274-4065

Provider Location

Appointment Details	
Date: _____ Time: _____	

PHARMACY: Process all prescriptions online through CorVel's pharmacy program for this patient and DO NOT charge the patient for the prescription. Call CorVel at (800) 563-6436 (Mon - 11pm, M-F) for additional assistance. The Member ID is a 9 digit social security number plus a digit code of injury.

PARTICIPATING PHARMACIES*

CVS Pharmacy	Walgreens	Bullitt Food & Drug Center
Costco Pharmacy	Kroger Pharmacy	Ray's Stop Supermarket Co.
Dominick's Fine Foods	Medicine Shop International	Target Pharmacy
Meijer Inc.	Wegmans Pharmacy	Wegmans Pharmacy
Old Navy Pharmacy	Publix Pharmacies	Wal-Mart Pharmacy
Old Post Stores LLC	Wal-Mart Pharmacy	Wal-Mart Pharmacy
Old Post Drug Store	Wal-Mart Pharmacy	Wal-Mart Pharmacy
	Wal-Mart Pharmacy	Wal-Mart Pharmacy

*This is only a partial list of the over 70,000 participating pharmacies in the CorVel Network. Please call (800) 563-6436 for additional locations.

Rev. Aug 2011

Temporary Pharmacy Card
(First Fill Only)

DOB: 00/00
POB: AZN
RX Group:
Member ID: SSN + Date of Injury
acc: 12345678901212011

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

CORVEL Physician's Report

EMPLOYEE: Take this form with you and have the treating physician complete the Physician section below.
 Employee name: Joni Anthony Record ID: KW-13-019017
 Date of injury: 02/05/2019 Physician's Facility:

PHYSICIAN: For compliance, please complete this section and email to RTWG@onlinecapstracenter.com or fax to (800) 381-4320. This document authorizes initial evaluation and treatment only, and payment for these services will be included without prejudice.

DIAGNOSIS _____
 A prescribed drug used (check one): has been completed has not been completed

INSTRUCTIONS:
 In accordance with the patient's physical capability, check all that apply:

May resume work immediately, no restrictions.
 May resume work immediately, with the following restrictions:
 Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
 Light work (lifting less than 20 pounds) Medium work (lifting less than 50 pounds)
 Limited hours, _____ hours per day Limited days, _____ days per week
 Other, _____
 Repetitive motion restrictions (specific to hand/arm injuries):

FREQUENCY	No Use	Occasional	Frequent	Constant
LEFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient is unable to return to work in any capacity.

RETURN TO WORK/NEXT APPOINTMENT:
 Date patient may return to work at full duty: _____
 Projected date of attainment of Maximum Medical Improvement: _____
 Patient has a return appointment on (date) _____ at (time) _____ AM/PM

ANCILLARY SERVICES:
 Please call (800) 386-1101 if patient requires Physical Therapy, Imaging, DME, Transportation or Translation services.
 Physician Name: _____ Date: _____
 Physician Signature: _____

Rev. Aug 2013

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

View Intake Status: Completed

- 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

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:

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

Name	SSN	DOB	EEID#	City/State	Customer	Action
John Smith	***-**-1122	04/22	00000000	Portland, OR	Acme	<input type="button" value="Select"/>

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

Glossary

M

My Term

My definition