WORKERS COMPENSATION CLAIM TRANSMITTAL FORM

To: Cannon Cochran Management Services, Inc.
3333 Warrenville Road, Suite 550
Lisle, IL 60532

From: ______________________________
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Claimant: ___________________________

1) **Illinois Form 45 and the Supervisor's Investigation Report must be attached for all claims**

2) **Medical Authorization Form**

3) **Drug Test Results**

4) **Initial Assessment** (see back for description)

____ Injury Verified

____ Injury Questioned

____ Injury Disputed

____ No Lost Time

____ Lost Time (Off 3 or more scheduled work days)

5) **Lost time claims require the following information:**

____ Wage Statement (52 weeks of wages prior to date of injury excluding overtime)

____ The first 4 scheduled days missed excluding the date of injury

_____/_____/_____ 1st scheduled day missed

_____/_____/_____ 2nd scheduled day missed

_____/_____/_____ 3rd scheduled day missed

_____/_____/_____ 4th scheduled day missed

_____/_____/_____ Date of hire

_____/_____/_____ Date the claimant returned to work. If the claimant has not returned to work yet, please notify our office the day the claimant returns to work.

(____)__________ Claimant's home phone number

Initial Assessment Description

Injury Verified - Specific incident cited. Facts support claimant's statement of injury. Medical bills & disability payments should be expedited.

Injury Questioned - Employer has doubt regarding incident.
Examples:

1) Doubt if injury occurred.
2) Injury was not reported immediately.
3) Conflicting statements by claimant and/or witnesses.
4) Injury type does not correspond with incident details.
5) Injury may not be work related.

Injury Disputed - Facts do not support claimant's statement of injury