This form only displays data that has been changed on this 02 transaction.
Please view FROI/SROI in eCase for the most current data listed on this case file.

F6662387

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name Fake Case

WCB Case Number (JCN) 55555557

Date of Injury 01/01/2017

Claim Administrator Claim Number 55555557

Maintenance Type Code Date 02/13/2024

Claim Type

WCB Received Date 02/13/2024

Agreement to Compensate

INSURER INFORMATION

Insurer Name

FEIN xxxxx9999

Insurer Type

Insurer ID W999999

CLAIM ADMINISTRATOR INFORMATION

Name

Info/Attn

Address

City

State

Postal Code

Country

FEIN xxxxx9999

Claim Admin ID W999999

Late Reason

Claim Representative Name

Claim Representative Business Phone Number

Claim Representative E-mail Address

FULL DENIAL REASONS

Full Denial Effective Date

EMPLOYEE INFORMATION

First Name: Fake
Middle Name/Initial:

Last Name: Case
Suffix:

Mailing Address:

City:
State:

Postal Code:
Country:

Phone Number:
Gender:

Date of Birth: 01/02/1963
Date of Hire:

Employee ID Type: S - Employee Social Security Number
Employee ID: xxxxx7777

Occupation Description:

Employee Email Address:

CLAIM INFORMATION

Time of injury:
Date Employer Had Knowledge of the Injury:

Employment Status:
Date Claim Administrator Had Knowledge of the Injury:

Wage Period:
Initial Date Employer Had Knowledge of Date of Disability:

Estimated Wage:
Current Date Employer had Knowledge of Current Date of Disability:

Work Week Type:
Number of Days Worked Per Week:

Date of Denial Rescission:
Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury:
Employer Paid Salary in Lieu of Compensation:

Death Result of Injury:
Date of Death:
Number of Dependents:

Nature of Injury:

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location

Cause of Injury:

Type of Loss:

Accident/Injury Description

WORK STATUS

Initial Date Last Day Worked		Initial RTW Type Code	
Initial Date Disability Began		Initial RTW Physical Restrictions	
Initial RTW Date		Initial RTW With Same Employer	
Latest RTW Type Code		Latest RTW Physical Restrictions	
Latest RTW/Status Date		Latest RTW With Same Employer	
Current Date Disability Began		Current Date Last Day Worked	
		First Day of Disability After the Waiting Period	

ACCIDENT LOCATION AND WITNESSES

Premises ______________________

Organization Name ______________________

Street		State	
City		Postal Code	
County/Parish		Country	

Location Narrative ______________________

Witnesses	Business Phone Number

MEDICAL TREATMENT

Initial Treatment ______________________

Managed Care Org. ______________________

Managed Care Org. ID ______________________

EMPLOYER INFORMATION

Name ______________________ Employer FEIN xxxxx4234

Industry Code ______________________ UI Number ______________________

Manual Classification ______________________

Info/Attn ______________________

Mailing Address ______________________

City ______________________ State ______________________

Postal Code ______________________ Country ______________________

Physical Addr ______________________

City ______________________ State ______________________

Postal Code ______________________ Country ______________________

Contact Name ______________________

Contact Business Phone Number ______________________

INSURED INFORMATION

Insured Name ______________________ Insured FEIN ______________________

Insured Type ______________________ Insured Location ID ______________________

Policy Number ID ______________________

Policy Effective Date ______________________ Policy Expiration Date ______________________

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0205 - Work Days Scheduled Code	R - Remove