

Claims

Claims Management of Missouri, LLC

Mgmt of MO

Internet Claims Reporting Website: [www.claimsmgmtmo.com](http://www.claimsmgmtmo.com)

**\*\* System Requirements: Internet Explorer, Adobe Reader, Word \*\***

**\*\* System should be in "Compatibility View" and "Pop-up Blocker" should be turned "OFF" \*\***

Insured Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

User ID: \_\_\_\_\_

Password: **JW\_software** (case sensitive)

MMMA - Windows Internet Explorer provided by Hays Companies  
http://claimsmgmtmo.com/

Claims Management of Missouri, LLC  
Mgmt of MO

HOME ABOUT US CONTACT US CLAIMS FO

**WORK INJURY CLAIM FORM**

**1 WORKER'S PERSONAL DETAILS**

Title Family Name  
Given names  
Other known or previous legal names, eg maiden name  
Date of birth Gender  Male  Female  
Street address  
Suburb  
State  
Postcode  
Home telephone  
Work telephone  
Home fax  
Work fax  
Email address  
Correspondence

What is the street address where the incident occurred?  
Suburb  
State  
Name of employer responsible for this workplace  
Which of the following incident circumstances apply?  
 While working at your usual workplace  
 While working away from your usual workplace  
 During a meal-break or authorised recess at work  
 While away from work during a recess  
 While on or from work  
 While on or from a vehicle  
If the incident while you were working involved driving or using a motor vehicle, please provide the following details:  
Type of vehicle  
State  
Year of manufacture  
Registration number  
Type of accident  
How was caused or

Claims Management of LLC

**START** **GO!**

**Our Services**

- Best Practices Standards
- Dedicated Claims Professionals
- Consistent Claims Management
- Medical Bill & Pharmacy Review

Click **START** to begin

The Initial Login Screen will look like the following:



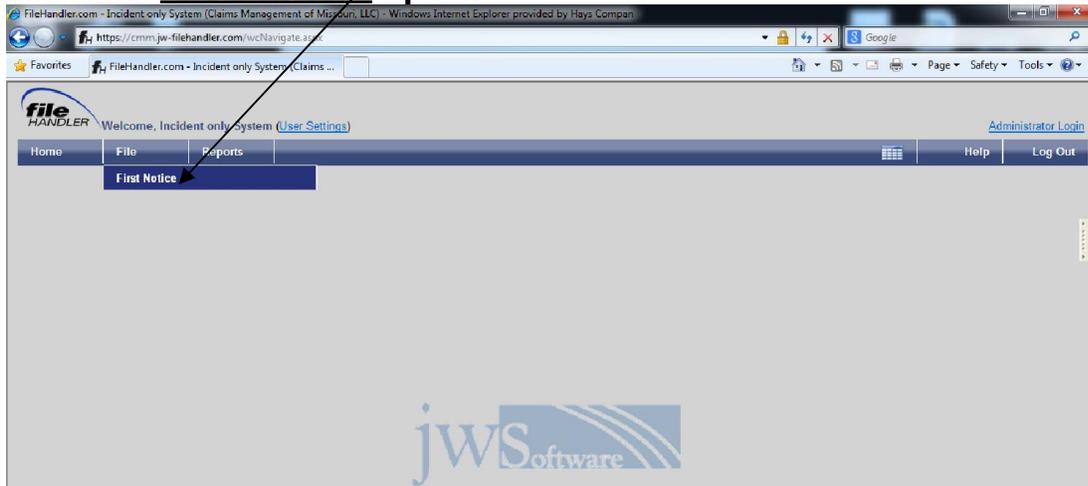
The first time you login you will be prompted to change your password

NOTE: Passwords are HIPPA compliant – so they must adhere to the following rules:

- Password must be between 8 and 15 characters
- Password and user name cannot be a subset of the other
- Password must contain one character from at least 3 of the following 4 character sets:
  - Upper Case Alpha:
  - Lower Case Alpha:
  - Numeric Characters:
  - Special Characters:

Once you get into the Program, you will want to go to the Claim drop down menu (File Folder icon ) **Mandatory fields are indicated with an \***

# Select the FIRST NOTICE Option



This screenshot shows the 'First Notice of Loss' form in the FileHandler.com system. The form is titled 'First notice of loss Step 1 of 2' and contains the following fields:

- Claim category: Reserved
- \* Client: MO. MERCHANTS & MANUFACTURERS (MMMA) - 07154
- \* Tier2: [Empty]
- Tier3: [Empty]
- Tier4: [Empty]
- Tier5: [Empty]
- Tier6: [Empty]
- \* Received date: 10/10/2013 \* Time: 01:10 PM
- \* Loss date: 10/01/2013 \* Time: 12:00 AM
- \* Date reported: 10/04/2013 \* Time: 12:00 AM
- Policy: Missouri Merchants & Manufacturers, 03/01/1992 - 12/31/2014
- Policy Location: All Locations Chesterfield, MO 63017
- Class Code: 8810 - Clerical
- First name: [Empty] MI: [Empty]
- \* Last name: TEST CLAIM
- Home phone: [Empty]
- Address1: [Empty]
- Address2: [Empty]
- C/SIZ: [Empty]
- Hire date: [Empty]
- OSHA Y/N: Yes
- \* Controlling State: MO
- \* Claim Type: - Medical Only
- Accident Address1: [Empty]
- Accident Address2: [Empty]
- Accident C/SIZ: [Empty]
- REMARKS: EMPLOYEE WAS RACING MOTORCYCLES OVER THE WEEKEND
- Lost Day Reason: [Empty]
- \* Your name: Incident only System
- Your title: Claims Coordinator
- \* Your phone: (636) 681-5277
- \* Your Email Address: kwhorl@mmm-a.com

At the bottom of the form, there are two buttons: 'Cancel' and 'Next >'.

## **DEFINITIONS:**

**OSHA:** A **Yes** on OSHA reportable claims gives the employer the ability to track/create on-line OSHA 300 logs

**CONTROLLING STATE: MO**

**CLAIM TYPE:** (*ALL claim types must be reported*)

1. **Incident Only** = Reporting purposes only – NO medical treatment
2. **Medical Only** - Injured worker seeks medical treatment from physician
3. **Lost Time/Indemnity** = Injured worker seeks treatment and is off work, questionable claim, 3<sup>rd</sup> party claim, litigated claim, etc.

**REMARKS:** Employer generic field to place additional comments regarding injury.  
*This field is for informational purposes and is NOT transferred to First Notice of Loss (Report of Injury)*

Select **NEXT** to get to the **First Report of Injury Screen**

## Mandatory fields are green/optional fields are yellow

\* Please note the mandatory fields noted are for reporting the claim to CLAIMS MGMT. Additional mandatory fields may be necessary for submission with State. Please complete as many fields as possible at the time of reporting.

FileHandler.com - Incident only System (Claims Management of Missouri, LLC) - Windows Internet Explorer provided by Hays Compan

https://cmm.jw-filehandler.com/wcNavigate.aspx?WCID=wiFirstLossNotice&WCE=FirstLossNotice

FileHandler.com - Incident only System (Claims ...)

**file HANDLER** Welcome, Incident only System (User Settings) Administrator Login

Home File Reports Help Log Out

First Notice of Loss

**MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS**  
**DIVISION OF WORKERS' COMPENSATION**  
**REPORT OF INJURY**

P.O. BOX 58  
 JEFFERSON CITY, MO 65102-0058  
 (To complete form, see attached instructions)

<b>GENERAL</b>	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE) Name: * Addr1: * Addr2: * City: * S/C: *	CARRIER ADMINISTRATOR CLAIM NUMBER 00	REPORT PURPOSE CODE	
	SIC CODE: 34425C EMPLOYER FEIN: *	JURISDICTION: MO JURISDICTION CLAIM NUMBER: *	INSURED REPORT NUMBER: *	
	CARRIER (NAME, ADDRESS & PHONE NO.) MMMAWCF Mo Merchants & Manufacturers W/C Fund 16100 Chesterfield Pkwy W, Ste 210 St. Louis, MO 63017 (636) 537-1360	POLICY PERIOD 03/01/1992 to 12/31/2014 CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.) Claims Management of MO, LLC 16100 Chesterfield Parkway W Ste. 210 St. Louis, MO 63017 (636) 681-5288	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) Addr1: * Addr2: * LOCATION #: PHONE #:
	CARRIER FEIN: 436415220 INSURANCE POLICY NUMBER: Missouri Merchants & Manufacturers ADMINISTRATOR FEIN: 273661462	AGENT NAME & CODE NUMBER Code: *	Name: *	
<b>EMPLOYEE</b>	NAME (LAST, FIRST, MIDDLE): * TEST CLAIM DATE OF BIRTH: * ADDRESS (INCL ZIP): * Addr1: * Addr2: * C/S/C: * PHONE #: *	SEX: * Unknown FEMALE UNKNOWN	MARITAL STATUS: * Unknown SINGLE DIVORCED MARRIED SEPARATED UNKNOWN	
<b>WAGE</b>	RATE: * DAY MONTH OTHER <input checked="" type="checkbox"/> WEEK # OF DAYS WORKED/WEEK: * FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE? *	DATE EMPLOYEE BEGAN WORK: * AM PM 10/01/2013	DATE OF OCCURRENCE: * AM PM 12:00 AM	
<b>OCCURRENCE</b>	CONTACT NAME PHONE NUMBER L/F/M: * Ph: *	TYPE OF INJURY ILLNESS: * PART OF BODY AFFECTED: *	DATE EMPLOYER NOTIFIED: * DATE DISABILITY BEGAN: *	
<b>TREATMENT</b>	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS): * Name: * Addr: * C/S/C: * PHONE: *	HOSPITAL (NAME & ADDRESS): * Name: * Addr: * C/S/C: * PHONE: *	INITIAL TREATMENT: 1 - TREATED BY EMPLOYER 2 - MINOR CLINIC HOSPITAL 3 - EMERGENCY CASE 4 - HOSPITALIZED > 24 HOURS 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED	
<b>OTHERS</b>	WITNESS NAME: * DATE ADMINISTRATOR NOTIFIED: 10/10/2013 DATE PREPARED: 10/10/2013	PREPARED BY: * Incident only System TITLE: * Claims Coordinator PHONE NUMBER: * 636) 681-5277	CAUSE OF INJURY CODE: * DATE RETURN TO WORK: * IF FATAL GIVE DATE OF DEATH: * WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? * WERE THEY USED? *	

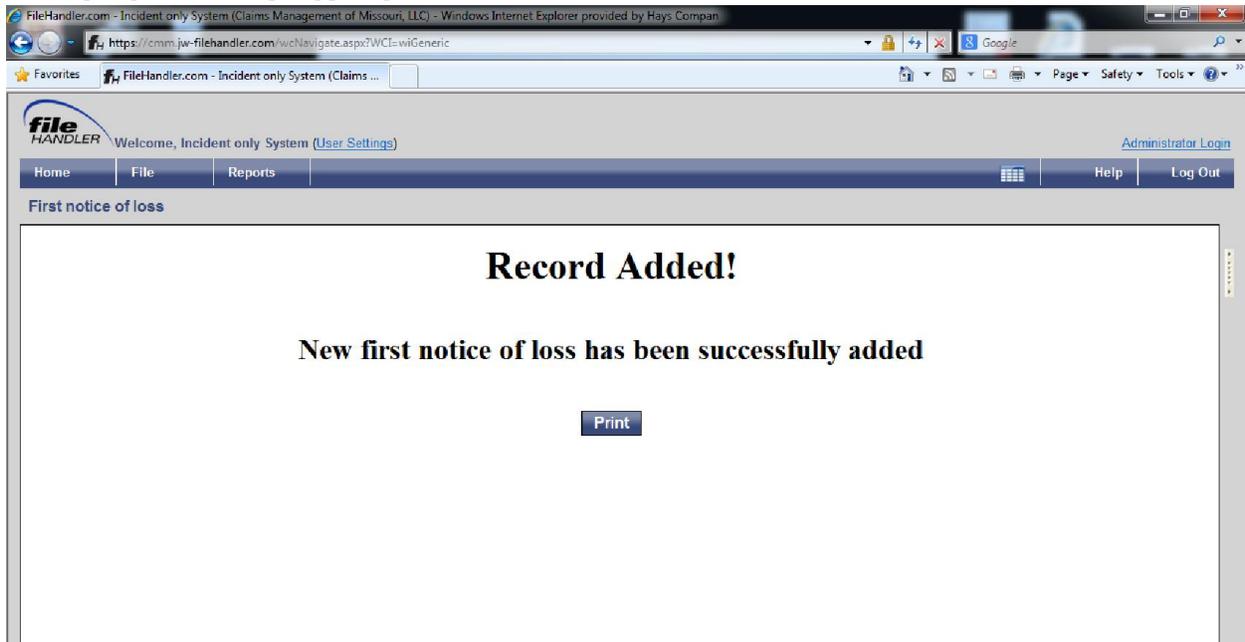
WC-1-EDI (01-04) AI

Cancel < Back Finish Save Work

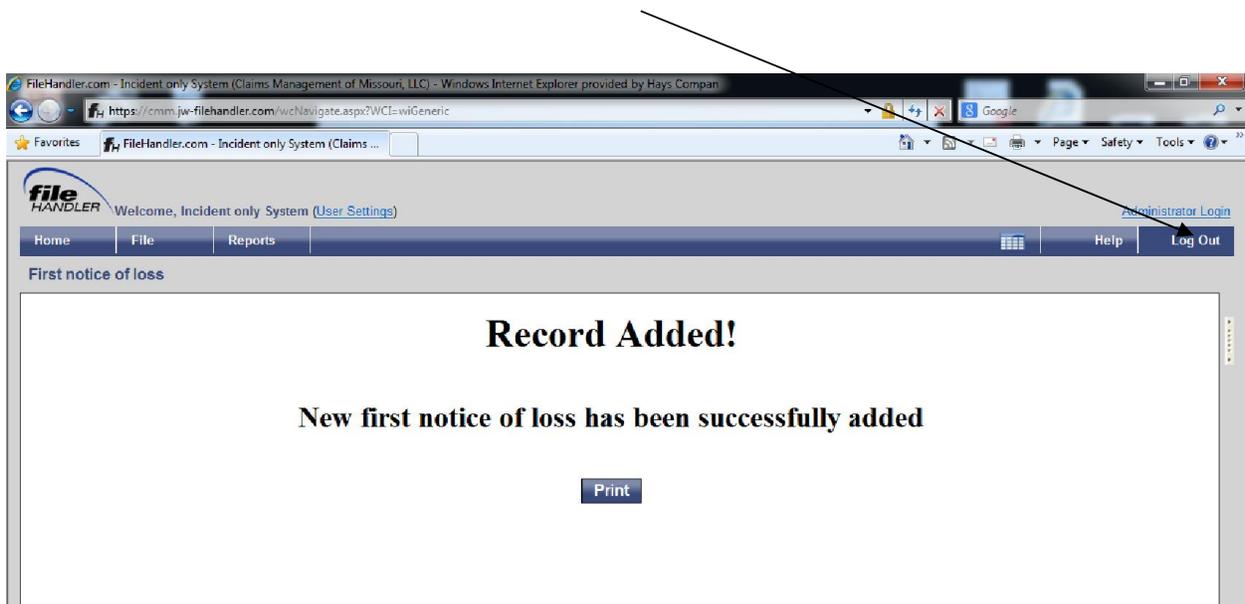
Trusted sites | Protected Mode: Off 125%

Select **FINISH** for the claim to be entered.

**You will receive the following message and be able to print the First Notice of Loss (*Report of Injury*) if you wish.**



**You have now completed entering a claim! *Once you are done entering claims, please make sure to log off using the log off button***



**Once the First Notice (*Report of Injury*) is reviewed and accepted by Claim Management of Missouri, you will receive a confirmation email (*to the email address you provided*) with the claim number.**

**\* You may need to hit the Internet Refresh Button at next sign-on.**

**Questions?**

**Direct Dial Phone: (636) 537-4613**

**Toll-Free: (877) 936-0151**