Claims | Claims Management of Missouri, LLC | Mgmt of MO

"INCIDENT REPORT" – DECLINE MEDICAL TREATMENT FORM

****Supplement to Employers' First Notice of Loss (FNOL)**

Today's Date: ________________________________

Employee: ____
Date of Stated Injury: ____
Time of Stated Injury: ____
Location of Injury: ____
Description of Injury: ____
Body Part(s) Affected: ____

The above employee has stated that a workers' compensation accident/incident has occurred at the above date, place and time.

At the request of the employee, he/she does not wish to seek the offered medical treatment at our authorized provider for workers' compensation. The Employee has been advised of his/her Mo. workers' compensation benefits in conjunction with the post-accident policy of the employer.

____ Date: ____________________
(Employee Signature)

A copy of this form will be provided to the employee and if he/she does wish to seek medical treatment at a future date, the employee is to advise the workers' compensation benefits manager immediately. **Please be advised: This employer "only" authorizes the following facility as our "initial" workers' compensation medical provider:**

AUTHORIZED MEDICAL PROVIDER:____

____
(Employer's Representative)

____
(Title)

** **Please Note** **
Should the employee choose to seek medical treatment from any other provider (other than what is approved above), all payments will be at the employee's own expense.