MEDICAL ONLY: YES OR NO

OUT OF WORK: YES OR NO

NUMBER OF DAYS MISSED: ______

If employee is disabled for 5 or more days, please notify Sue Brouwer sbrouwer@hopedale-ma.gov

MEDICAL ONLY NOTICE OF INJURY

(* Represents fields necessary for the MEGA Claims Representative to set up the claim)

*Employer: ________________________________ MEGA Location #: X340______

*Employee's Name________________________________ *DOB: ____________________________

*Address ____

*City________________________________*State______________*Zip Code_______________

Home Phone #: ______________________ *Social Security #: ______________________________

Department: ___________________ Job Title: _______________________ DOH: ______________

Rate of Pay: ______________________ *Date of Incident ___/___/____ Time ____________

Location _________________________________ Body Part: ________________________________

Type of Injury (strain, laceration, etc.) ____

Describe what happened ____

____

Name of Witness(es) ____

To whom was accident/incident reported to? _____________________Date Reported__________

*Was medical attention sought? Yes ___ No ____ If yes, *Where? ___________________________

*Date employee RETURNED TO WORK?

Information Release

I hereby authorize Massachusetts Education and Government Association Property & Casualty Group, Inc. (MEGA), or any of its representatives to be furnished any information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury and for no other purpose, now or in the future.

Employee Signature: ____________________________________ Date: _______________________

Supervisor Comments ____

Supervisor Signature: ____________________________________ Date: _______________________

Please mail or fax completed form:

55 Walkers Brook Drive, Suite 402 Reading MA 01867
Phone: 781-683-1000 Fax: 781-246-3425

TOWN OF HOPEDALE

78 Hopedale Street - P.O. Box 7
Hopedale, Massachusetts 01747

Tel: 508-634-2203 x 210 Fax: 508-634-2200
sbrouwer@hopedale-ma.gov

Town Administrator
Steven A. Sette

IMPORTANT: If an employee is injured on duty, **prior to seeking treatment**, complete this form, make several copies of completed form and give to employee to bring to the provider (hospital and/or doctor's office, testing). Otherwise, the provider(s) will bill the employee and they will need to submit to our office for processing.

Workman's Compensation Billing for Town of Hopedale

Employee Name:____

Address:____

Phone: Home:____________________ Work:____________________

Date of Injury:___________________________ *Claim #:_________________

Type of Injury and location:_______________________________________

Employee's Supervisor: ________________________Tel:______________________

Attention Providers:** ***Please note claim numbers are assigned by the insurance carrier and may not be available at the time employee seeks treatment. The Town of Hopedale does not approve treatment. All approvals for treatment must go through the insurance carrier.

Town and School Employees Workers' Comp. Insurance Carrier Billing Information

Coverage Period: 7/1/2018 to 6/30/2019
Policy Number: WCX34054550013

Name: MEGA (Mass. Education & Govt. Assoc.) c/o CCMSI
Address 55 Walkers Brook Drive, Suite 402 Reading, MA 01867

Telephone: 781-683-1104 Fax: 781-246-3425

Town of Hopedale Workers' Comp. Insurance Agency Contact Information

Name: Berry Insurance Agency
Address: 31 Haywood Street, Suite J
Franklin, MA 02038

Telephone: 800-941-3317 Fax: 508-440-2291

Town of Hopedale Workers' Contact Information

Employer Contact: Susan Brouwer, Executive Assistant
Address: PO Box 7, 78 Hopedale Street Hopedale, MA 01747

Telephone: 508 634-2203 X 210
Email: **sbrouwer@hopedale-ma.gov**