**CLAIM TRACKING CHECKLIST TEMPLATE**

DEMOGRAPHIC INFORMATION

|  |  |  |
| --- | --- | --- |
| INJURED EMPLOYEE NAME | TITLE | EMPLOYEE ID |
|  |  |  |
| DEPARTMENT | DATE OF INCIDENT |
|  |  |
| TYPE OF INCIDENT | CLAIM NO. |
|  |  |

WORK STATUS

|  |  |
| --- | --- |
| SCHEDULED RETURN TO WORK DATE | ACTUAL RETURN TO WORK DATE |
|  |  |
| NOTES |
|  |

TRACKING ITEMS

|  |  |  |  |
| --- | --- | --- | --- |
| **ITEM NAME** | **STATUS** | **ASSIGNED TO** | **DATE COMPLETED** |
| **Accident Reporting Forms:** |  |  |  |
| Employee Incident/Accident Report |  |  |  |
| Back Injury Incident/Accident Report |  |  |  |
| Supervisor’s Investigation Report |  |  |  |
| Witness Statement Form |  |  |  |
| First Report of Injury Form |  |  |  |
| Managed Care Organization (MCO) Notified |  |  |  |
| Third Party Administrator (TPA) Notified |  |  |  |
| Claim Certification (Approved or Denied) |  |  |  |
| Supervisor Report of Return to Work |  |  |  |
| Return to Work Plan Development |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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