

How to File a Claim

Portal Instruction Guide – Policyholders

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File a Claim

1. On the home screen, select the **Orange File a Claim Envelope**.

The screenshot shows the Previsor/MEM portal home screen. At the top, there are navigation tabs for Billing, Claims, Resources, and Reports. Below this is an 'Account Summary' section with four cards: 'My Balance' (showing '-'), 'My Renewal' (Status: Not Found), 'My Next Bill' (Amount: \$25.00, Due: Apr 21, 2022), and 'My Last Payment' (Amount: \$41,583.00, Paid: Jan 28, 2022). Below the account summary is a 'Policies' section with a table of active policies. The table has columns for Policy #, Policy Term, Status, Premium, Generate COI, File a Claim, and Report Payroll. A red box highlights the 'File a Claim' button (represented by an envelope icon) for the policy with ID 3004435. A 'Download' button is also visible in the top right of the policies section.

| Policy # | Policy Term | Status | Premium | Generate COI | File a Claim | Report Payroll |
|----------|-------------------|----------|--------------|--------------|--------------|----------------|
| 3004435 | Feb 1, 2022 - Feb | In Force | \$317,001.20 | | | |

2. Select **Start**.

Account: Kirchman Exteriors 10000123456
Workers Compensation (10000357933)

Has someone been injured at work? Act now by following these steps:

Helpful Information:

- [Injury Management Kit](#)
- [Post-Incident Drug Screening](#)
- [Return To Work Plan](#)
- [Prevent Fraud](#)

- 1. Assess the injury**
If the injury involves a lot of blood, a head injury or transported by ambulance or air-lifted, please contact 911 immediately.
Feel free to call our 24/7 Nurse Aid Work Injury Line at 1.800.442.0593 for a treatment recommendation from a registered nurse.
- 2. Review Injury Management Kit**
This free web-based kit can help you or your staff assess "next steps" when managing your claims. [Click here](#) to download the kit now.
- 3. File your claim online**
It takes less than 5 minutes to file a claim online. Please click "Start" to begin.

Cancel **Start**

Basic Information

1. Select the **Radio Button** next to the **Policy Number** for which the claim should be filed.
2. Enter the **Date/Time When Did the Incident/Injury Occur** or select the **Calendar Icon** to select the date and time.

First Report of Injury

All fields in this report are mandatory for reporting to the appropriate state or federal agency, but some fields are not required in order to simply begin the claims process. Claims are serviced by MEM and you will be contacted to obtain any missing information – including information from 'optional' fields.

Selected Policy Number -

When did the incident/injury occur? AM PM
If the time of loss is unknown, enter the time as 12:00 pm

Select A Policy **Policy #** 1234567

Date you were notified of the incident/injury?

Cancel **Next**

NOTE: The date defaults to today's date, click the calendar icon to select a previous date.

NOTE: If the time is unknown enter the time as 12:00 PM.

NOTE: Once a policy is selected, the associated business name, insurance agent, and selected policy number populates on the screen.

3. Enter the **Date You Were Notified of the Occurrence** or select the **Calendar Icon** to select the date and time.
4. Select **Next**.

First Report of Injury

All fields in this report are mandatory for reporting to the appropriate state or federal agency, but some fields are not required in order to simply begin the claims process. Claims are serviced by MEM and you will be contacted to obtain any missing information – including information from 'optional' fields.

| | |
|---|--|
| Kirchman Exteriors LLC 801 East Broadway Columbia MO 65203 | The agent for this policy is: ABC Insurance Company PO Box 1768 Columbia MO 65203 |
|---|--|

Covered State(s): MO

Selected Policy Number: 3004435

When did the incident/injury occur? AM PM
If the time of loss is unknown, enter the time as 12:00 pm

Select A Policy Policy # 1234567

Date you were notified of the incident/injury?

General Claim Information

1. To add a contact, enter the required **First Name** and **Last Name**.
2. Enter any known **Optional Information** on the injured party (**Phone, Phone Type, SSN, Date of Birth, Gender, Marital Status, Occupation, Address, Zip Code, City, State, and E-Mail**).

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First Report of Injury

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Injured Worker

| | |
|-----------------------------|---|
| First Name | <input type="text" value="Taylor"/> |
| Middle Name (Optional) | <input type="text" value="Henry"/> |
| Last Name | <input type="text" value="Smith"/> |
| Phone (Optional) | <input type="text" value="573-289-1458"/> |
| Phone Type (Optional) | <input checked="" type="radio"/> Mobile <input type="radio"/> Home <input type="radio"/> Work |
| SSN (Optional) | <input type="text" value="123-45-6789"/> |
| Date of Birth (Optional) | <input type="text" value="May 6, 1981"/> |
| Gender (Optional) | <input type="text" value="Male"/> |
| Marital Status (Optional) | <input type="text" value="Married"/> |
| Occupation (Optional) | <input type="text" value="Sales Associate"/> |
| <hr/> | |
| Address Line 1 (Optional) | <input type="text" value="4404 County Woods Rd"/> |
| Address Line 2 (Optional) | <input type="text"/> |
| Zip Code (Optional) | <input type="text" value="65203"/> |
| City (Optional) | <input type="text" value="Columbia"/> |
| State (Optional) | <input type="text" value="Missouri"/> |
| E-Mail (Optional) | <input type="text" value="taylor.h.smith@gmail.com"/> |
| Alternate E-Mail (Optional) | <input type="text"/> |

3. Select the **State of Hire** from the pre-populated list of states for which the policy provides coverage.
4. Enter or select any known **Optional Information** on the injured party (**Date of Hire, Employment Status, Primary Work Location, Primary Work Class Code, Wage Rate, Time Work Began, Number of Days Worked Per Week, Number of Days the Business is Open, Full Pay for Day of Injury, Did Salary Continue**).

NOTE: Primary Work Location and Primary Work Class Code will pre-populate based on the associated location and class code on the policy. If one of these values does not pertain to the claim, select another value from the dropdown in each field.

NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

| | |
|--|--|
| State of Hire | Missouri |
| Date of Hire (Optional) | Jan 6, 2020 |
| Employment Status (Optional) | Regular Full-time Employee |
| Primary Work Location (Optional) | 1: 801 East Broadway Columbia, MO 65203 |
| Primary Work Class Code (Optional) | 9102 - PARK NOC-ALL EMPLOYEES & DRIVERS. |
| Wage Rate (Optional) | USD 23.00 per (Optional) Hour |
| Time Began Work (Optional) | 08:00 <input checked="" type="radio"/> AM <input type="radio"/> PM |
| Number of Days Worked per Week (Optional) | 5 |
| Number of Days Business is Open (Optional) | 5 |
| Full Pay for Day of Injury? (Optional) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Did Salary Continue? (Optional) | <input checked="" type="radio"/> Yes <input type="radio"/> No |

5. Select the **Injury Cause/Source**.
6. Input brief **Incident Details**.
7. Enter or select any known **Optional Information** regarding what happened (**Incident Description, Were Safeguards or Safety Equipment Provided, Were Safeguards or Safety Equipment Used, Was There a Mechanical Defect That Caused the Loss, Were Safety Rules Violated, Are the Use of Drugs or Alcohol Suspected, Does the Policyholder Question if the Injury is Work Related**), if applicable.

NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

NOTE: The **Incident Description** box can be used to elaborate on the story or situation around the incident; however, please know any information included in the box may be admissible in the event this case is addressed in a courtroom.

Describe what happened

Injury Cause/Source: Cut, puncture, scrape, injured by

Incident Details: Cut pinky finger with box knife

Please be brief but descriptive; will be used for notification with the state of jurisdiction

Incident Description (Optional): -Professional Contextual story up to 1,000 characters-

Were Safeguards or Safety Equipment Provided? (Optional): Yes No

Were the Safeguards or Safety Equipment Used? (Optional): Yes No

Was there a Mechanical defect that caused the loss? (Optional): No

Were safety rules violated? (Optional): No

Are the use of drugs or alcohol suspected? (Optional): No

Does the policyholder question if the injury is work related? (Optional): No

You will have an opportunity to upload documents to this claim later in the process

8. *If the policyholder questions if the injury is work related, input a Reason Employer Questions Claim.*

Does the policyholder question if the injury is work related? (Optional): Yes

Reason Employer Questions Claims

9. Select **Next**.

Save and Exit Previous **Next**

Injury Details

1. Enter **Type of Injury/Parts of Body Affected**.
2. *If the injured worker received treatment for their injury, select any known **Optional Fields** regarding medical treatment (**Clinic/Provider, Initial Treatment, and/or Hospital.**)*

First Report of Injury

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Body Part Details

Please use the text box to type in a brief description of injuries, including the affected body parts.

Click [here](#) for definitions related to body part details

Type of Injury/Parts of Body Affected (Optional)

Medical Treatment

Clinic/Provider (Optional)

Initial Treatment (Optional)

Hospital (Optional)

Hospital: Cap Region Jefferson City
 Capital Region ER
 Capital Region Edgewood Urgent Care
 Capital Region Medical Clinic
 Capital Region Urgent Care
 Capital Region Urgent Care Clinic

Work Status

Work Status Type Release Date Comment

NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

3. *If the treatment provided is not listed in the drop down, select **Add**.*
4. Enter the **Hospital Name**.
5. Enter any known Optional Fields regarding the provider (**Country, Address, Zip Code, City, State, Phone, Fax, Email**).
6. Select **Ok**.

First Report of Injury

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Hospital

| Primary Address | | Contact Info | |
|---------------------------------|---|-----------------------------|---|
| Country | <input type="text" value="United States"/> | Work (Optional) | <input type="text" value="573-882-1662"/> |
| Address Line 1 | <input type="text" value="3916 S PROVIDENCE RD"/> | Alt Phone (Optional) | <input type="text"/> |
| Address Line 2 (Optional) | <input type="text"/> | Fax (Optional) | <input type="text"/> |
| Zip Code | <input type="text" value="65203-7152"/> | E-Mail (Optional) | <input type="text"/> |
| City (Optional) | <input type="text" value="COLUMBIA"/> | Alternate E-Mail (Optional) | <input type="text"/> |
| State | <input type="text" value="Missouri"/> | | |
| Address Type (Optional) | <input type="text" value="Business"/> | | |
| Location Description (Optional) | <input type="text"/> | | |

- If the injured worker has returned to work, input any **Optional Fields** regarding work status (**Work Status Type, Release Date, Return Date, Reason and Comments**).
- Select **Add** if multiple work statuses need to be added.
- Input any known **Optional Fields** regarding work status (**Last Date Worked, Date Disability Began, Last Date Paid, Date of Death**), if applicable.

NOTE: Date Disability Began is defined as the first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.

NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

- Select **Next**.

Medical Treatment

Clinic/Provider (Optional)

Initial Treatment (Optional)

Hospital (Optional)

Work Status

| Work Status Type | Release Date | Return Date | Reason | Comment |
|--|---|---|--|----------------------|
| <input type="text" value="Full Duty - Rele..."/> | <input type="text" value="Mar 31, 2022"/> | <input type="text" value="Mar 31, 2022"/> | <input type="text" value="Please Select"/> | <input type="text"/> |

Last Date Worked (Optional)

Date Disability Began (Optional)

Last Date Paid (Optional)

If fatal, date of death (Optional)

Where

- Select the **Use a Policy Location** or **Specify Full Address Manually** radio button for Location of Incident.

NOTE: If a policy location is selected, the address details will automatically populate in the form below. If the policy has multiple known locations associated to the policy, use the drop-down to make the appropriate selection.

First Report of Injury

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Where Did the Incident Occur?

Location of Incident Use a Policy Location
 Specify Full Address Manually

Address Line 1 (Optional)

Address Line 2 (Optional)

Zip Code (Optional)

City (Optional)

State (Optional)

[Save and Exit](#) [Previous](#) [Next](#)

2. *If the Specify Full Address Manually radio button is selected, input Address, City, Zip Code and State.*
3. **Select Next.**

First Report of Injury

All fields in this report are mandatory for reporting to the appropriate state or federal agency, but some fields are not required in order to simply begin the claims process. Claims are serviced by MEM and you will be contacted to obtain any missing information – including information from 'optional' fields.

Where Did the Incident Occur?

Location of Incident Use a Policy Location
 Specify Full Address Manually

Select Address (Optional)

Address **801 East Broadway**

-

-

City **Columbia**

ZIP Code **65203**

State **Missouri**

[Save and Exit](#) [Previous](#) [Next](#)

Contact Details

1. Enter the **First Name**, **Last Name** and **Phone Number** for the prepared by individual.
2. Input any known **Optional Fields** regarding the preparer (**Phone Number Type**, **Occupation**, **Email**).
3. Select the **Date Report Prepared**.

NOTE: The date reported field will default to today's date. To enter another date type in an alternate date or click the calendar icon to select a date.

4. *If the Main Contact is same as the Preparer*, select **Next** and skip to the [Additional Information](#) section.

First Report of Injury

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Prepared by

First Name

Middle Name (Optional)

Last Name

Phone

Phone Type (Optional) **Mobile** Home Work

Occupation (Optional)

E-Mail (Optional)

Alternate E-Mail (Optional)

Date report prepared

Is the Main Contact the same as Preparer? (Optional) **Yes** No

Save and Exit

5. *If the Main Contact is NOT the same as the Preparer*, select **No**.
6. Enter the **First Name**, **Last Name** and **Phone Number** for the main contact.
7. Input any known **Optional Fields** regarding the preparer (**Phone Number Type**, **Occupation**, **Email**).
8. Select **Next**.

Is the Main Contact the same as Preparer? (Optional) Yes No

Main Contact

First Name

Middle Name (Optional)

Last Name

Phone

Phone Type (Optional) Mobile Home Work

Occupation (Optional)

E-Mail (Optional)

Alternate E-Mail (Optional)

[Save and Exit](#) [Previous](#) [Next](#)

Additional Information

1. Complete any of the following **Optional Fields** regarding the claim (**Add Witness, Additional Details & Commentary**).
2. Select a **Report Filing**.
3. Select **Upload Documents** to upload any pictures, files, written testimonials, or other documentation to be included with the claim report.
4. Select **Next**.

First Report of Injury

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Witnesses
[Add Witness](#)

Additional Details & Commentary
Feel free to use this space to elaborate on the story or situation around this incident, however, please know any information included here may be admissible in the event this case is addressed in a courtroom.

Report Filing
To help file this report, consider the following options:
How are you filing this report?

Please Select
Med Only
Lost Time
Report Only

Upload Documents
Add photos or documents that are
[Upload Documents](#) Drag and drop files

[Save and Exit](#) [Previous](#) [Next](#)

Summary

1. Review the **Summary** information for accuracy.
2. Select **Submit Claim**.

First Report of Injury

All fields in this report are mandatory for reporting to the appropriate state or federal agency, but some fields are not required in order to simply begin the claims process. Claims are serviced by MEM and you will be contacted to obtain any missing information – including information from 'optional' fields.

Summary

Please review the following information before submitting:

| | |
|-----------------|------------------------------------|
| Policy Number | 3004435 |
| Injured Worker | Taylor Smith |
| When? | Mar 31, 2022, 2:00 PM |
| Where? | 801 E Broadway, Columbia, MO 65201 |
| Cause of Injury | Cut, puncture, scrape, injured by |
| Injury | Deep cut to left pinky finger |
| Contact Person | Bob Kirchman, 573-819-6457 |

Important notice: Claims are serviced by MEM and you will be contacted to obtain additional information.

Save and Exit
Previous
Submit Claim

3. A **Temporary Claim Number** is assigned.
4. *If desired*, select **Print Confirmation**.

Your claim has been submitted.

What Happens Next

Please check your email to view the completed injury report, or navigate to the "Documents" tab to view a PDF copy. You can upload documents related to this claim to the portal and by:

MISSOURI EMPLOYERS MUTUAL

claims@mem-ins.com

1.800.442.0597

Missouri Employers Mutual

PO Box 1810

Columbia, MO 65205

Temporary Claim No: 51241

Use this link to be placed in contact with our Nurse Triage team.

Back to Claims
Print Confirmation

The First Report of Injury has been submitted to MEM's Claims Services Unit. Your temporary claim number is 51241, but please note that this is not your claim number. A claims service representative will review your submission within one business day and if all data fields are complete to report to the appropriate jurisdictional agency a claim number and claims representative will be assigned at that time. If there is missing information the claims service representative will be in contact to obtain the necessary data and will then assign the claim number and claims representative. You will be able to view the completed FROI and initial claim letters on the documents screen for the claim.

When contacting us please...

Email: claims@mem-ins.com
Fax: 800-442-0597
Missouri Employers Mutual
PO Box 1810
Columbia, MO 65205

Live Chat

Where to Get Help

If your questions were not addressed within this document, please contact **MEM Customer Care** at customercare@mem-ins.com or by phone at 1.800.442.0593.