

DWC FORM 6 THROUGH YCE LOGIN

If you only need to submit a DWC-6 form, you will need to login to YCE directly and not go through the claim opening wizard (iCOW). The following instructions will get you to the same DWC-6 module. Save this link in your favorites!!!

<https://www.iclaimsexpert.com/>



You will click to login and then go to your main page. The Login and Password are the same that you will use for submitting a new claim. You will need to enter JIC as the Company name

The image shows the ClaimsExpert login page. It features the ClaimsExpert logo at the top left. Below the logo are three input fields: "Login:" with the text "susan.mulline", "Password:" with a masked password "*****", and "Company:" with the text "JIC" and a small "x" icon to the right. Below these fields is a "Login" button. Underneath the button is a link that says "Can't Login?". At the bottom of the page, there are links for "Copyright", "Terms Of Use", "Privacy Policy", and "ICE Home". A "SYSTEM ANNOUNCEMENTS" section is visible below the links. At the bottom right, there are three logos: "POWERED BY PROGRESS software", "APPLICATION PARTNER", and "Secured by iThawte" with a date "2015-08-19".

For purposes of these instructions, you will see the demo system screenshots.

Once you are in the system, you will need to locate the claim you want to submit the DWC-6 form on so

you will need to “search” for that claim. This function is on the left side of the screen under the icon. Select it to search for your claim:



You have several ways you can search, claim number, legacy claim number, name or SSN. I used name:

A screenshot of the "Claim Search" interface. On the left is the same navigation sidebar as in the previous image. At the top of the main area are several icons for different search criteria: Claims, Advanced, Clients, Insureds, Vendors, Coverage, and MBR. Below these icons is the "Claim Search" heading. The search form contains several input fields: "Claim Number:" (with a note "(this will also search Occurrence Id's and Related Claim Id's)"), "Legacy Claim Number:", "Client Claim Number:", "OWCP Claim Number:", "Claimant First Name:" (with "susan" entered), "Claimant Last Name:" (with "mullins" and a clear 'x' button), "Claimant SSN / TIN:", and "Claimant DOB:". At the bottom of the form are three buttons: "Search", "Recent Claims", and "Advanced Search".

Hit the search button. All claims with that name will be retrieved. For more common names, please make sure you select the right date of injury. You can narrow it down if you use the claim number if you have it available but many times the name is the fastest way. Once you identify the claim you want to work in, select it by moving your cursor to the claim number unscored in blue.

Claim Search (15 Claims Found) [Retain Results List in New Window]

Show Totals

| Claim | Claimant Name | LOB | Insured Name | Insured Location (1st) | Carrier | Accident | Status | Adjuster Name | Assigned |
|---|---------------|-----------------|----------------|------------------------|---------|------------|--------|-----------------|------------|
| 5584927 | Susan Mullins | TX WC Ind | Demo Insured A | 424- Columbus | SIR | 06/12/2015 | Open | David M Richard | 06/23/2015 |
| Description: Picking up a patient to a bed | | | | | | | | | |
| 5585871 | Susan Mullins | IL WC RPO | Demo Insured A | 424- Columbus | SIR | 06/24/2015 | Closed | David M Richard | 06/25/2015 |
| Description: Teacher dropped beaker in class. Cut finger on broken glass. | | | | | | | | | |
| 5596441 | Susan Mullins | IL WC RPO | Demo Insured A | 424- Columbus | SIR | 06/26/2015 | Closed | David M Richard | 06/26/2015 |
| Description: Teacher burned finger on chemicals. | | | | | | | | | |
| 5620523 | Susan Mullins | TX WC Ind | Demo Insured A | 424- Columbus | SIR | 08/01/2015 | Open | David M Richard | 08/13/2015 |
| Description: Lifting boxes | | | | | | | | | |
| 5670591 | Susan Mullins | TX WC Ind | Demo Insured A | 424- Columbus | SIR | 08/02/2015 | Open | David M Richard | 08/13/2015 |
| Description: Lifting boxes | | | | | | | | | |

Show Legend Cancel

You will see some of the same functionality with the DWC-6 forms as the DWC-3 forms. The same notification screen, same option to select or search for the form.

Forms and Letters
DWC-6 - Supplemental Report of Injury

Associated With: Claim
Document Type: All
Search Options: Refresh Listing

Form/Letter History
Sorry, no form/letter history available.

Attachment Options
 Attach PDF to Claim: 5685542

Email Options

| Title (optional) | Name (optional) | Email | Action |
|---------------------|-----------------|------------------------|-----------------------------------|
| User Opened By | Susan Mullins | susan.mullins@jicompar | Include: <input type="checkbox"/> |
| Adjuster Supervisor | David M Richard | David.Richard@tera.com | Include: <input type="checkbox"/> |

Add Email

Back Request Form

Forms and Letters

Associated With: Claim

Document Type: All +

Search Options: Refresh Listing

| Name | LOB | State |
|---|---------------|-------|
| DWC-6 - Supplemental Report of Injury | All LOB Codes | Texas |
| DWC-69 - Report of Medical Evaluation | All LOB Codes | Texas |

Form/Letter History
Sorry, no form/letter history available.

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The DWC-6 is also a PDF that you can type data directly on to and will prepopulate the demographics of the injured worker. Don't forget to select the "submit" button.

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records. Highlight Existing Fields

CLAIM # _____
Carrier # 5685542

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

| | |
|---|-----------------------------------|
| 1. Employer business name Demo Insured A | 2. Employer phone # 2268671367 |
| 3. Employer mailing address 1170 West Railroad Street, Long Beach, MS 39560 | |
| 4. Insurance carrier name Self-Insured | |
| 5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____ | |
| 6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/> | |
| 7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/> | |
| 8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/> | |
| 9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/> | |

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
 b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
 c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
 d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

| | | |
|---|------------------------|---|
| 11. Injured worker name Susan Mullins | 12. SSN xxx-xx-6789 | 13. DOI 08/05/2015 |
| 14. Injured worker mailing address and phone # 88 Maple St, Austin, TX 78757, 5128089999 | | |
| 15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | | 16. First day of additional lost time or reduced wages (mm/dd/yyyy) |

Please fill out the following form. You cannot save data typed into this form.
Please print your completed form if you would like a copy for your records.

17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes no
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
 Full duty, full pay
 Limited duty, full pay
 Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes no
 date of resignation _____ date of termination _____ date of death _____
 19a. Reason for resignation/termination _____
 19b. Was the injured worker on limited duty when terminated? yes no


20. Hours the injured worker was working during the pay period of _____ to _____ hours per week
 Indicated hours are:
 Increase from pre-injury
 Same as pre-injury
 Decrease from pre-injury

21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____
 Indicated wages are:
 Increase from pre-injury wage
 Same a pre-injury wage
 Decrease from pre-injury wage

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
 Submitted by: Employer Injured Worker (if no longer working for the employer where injury occurred.)

Signature and Title of person completing this form _____ Date _____



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