PROPRIETARY EDI FIRST REPORT OF INJURY FILE LAYOUT TABLE

HEADER RECORD – one record for each transmission

Field Name	Length of Field	Position of Field	Contents
Record Type	3	1-3	“HD1”
Trans Set ID	3	4-6	“ME1”
Sender ID	25	7-31	Insurer
Receiver ID	25	32-56	“WCB”
Transmission Date	8	57-64	mmddyyyy
Transmission Time	6	65-70	hhmmss
Test/Prod Indicator	1	71	“T” or “P”
Interchange Version ID	5	72-76	“1.0” or “2.0” or “148”

DATA RECORD – one record for each First Report

Field Name	Length of Field	Position of Field	Contents
1. WCBN#	8	1-8	

Reasons

Field Name	Length of Field	Position of Field	Contents
2a. Reason loss time	1	9	
2b. Employee Paid for 1/2day or more ?	1	10	* (Yes-y, No-n, N/A-blank)
3. Lost earnings/no LT	1	11	
4. Medical Healthcare	1	12	
5. Death	1	13	
Date of death	8	14-21	
6a. Occupational Disease	1	22	
6b. Date of Last Exposure	8	23-30	
6c. Date of Diagnosis	8	31-38	
7a. Correction of prior rpt	1	39	
7b. Date of Correction	8	40-47	
7c. Date Correction sent	8	48-55	

Field Name	Length of Field	Position of Field	Contents
Employer Information			
8. UIAN	10	56-65	
9. FEIN	9	66-74	
10. Employer Name	36	75-110	
10. Employer Name2	36	111-146	
11. Employer Addr1	24	147-170	
11. Employer Addr2	24	171-194	
12. Employer City	20	195-214	
13. Employer State	2	215-216	
14. Employer zip	6	217-222	* (see note below)
14. Employer zip ext	4	223-226	
15. Employer telephone	10	227-236	
16. Primary business	55	237-291	
17. Location Addr1	36	292-327	
17. Location Addr2	36	328-363	
17. Location Addr3	24	364-387	
17. Location Addr4	24	388-411	
17. Location City	20	412-431	
17. Location State	2	432-433	
17. Location zip	6	434-439	* (see note below)
17. Location zip ext	4	440-443	
18. Did injury occur on premises?	1	444	
18. Injury Location Name	36	445-480	
18. Injury Location Name2	36	481-516	
18. Injury Addr1	24	517-540	
18. Injury Addr2	24	541-564	
18. Injury City	20	565-584	
18. Injury State	2	585-586	
18. Injury zip	6	587-592	* (see note below)
18. Injury Zip Ext	4	593-596	

Insurer or Self-Administered Employer Information

Field Name	Length of Field	Position of Field	Contents
Insurer type	1	597	1=Insurer 3=Self-Administer **
20. Insurer Policy Number	20	598-617	
21. Insurer File Number	15	618-632	
NCCI	5	633-637	

* *Rest of insurer info on form is a lookup from the NCCI number

Field Name	Length of Field	Position of Field	Contents
Employee Information			
27. Last Name	14	638-651	
28. First Name	9	652-660	
29. Middle In	1	661	
30. Telephone	10	662-671	
31. SSN	9	672-680	
32. Gender	1	681 (M/F)	
33. Addr1	25	682-706	
34. City	19	707-725	
35. State	2	726-727	
36. Zip	6	728-733	* (see note below)
36. Zip Ext	4	734-737	
37. DOB	8	738-745	
38. Job Title	29	746-774	
39. Date of hire	8	775-782	
40. Weekly Wage	7	783-789	**format is numeric, no decimals points
41. Does employee work for another employer?	1	790	
41. Another employer name1	36	791-826	
41. Another employer name2	36	827-862	
41. Another employer addr1	24	863-886	
41. Another employer addr2	24	887-910	
41. Another employer city	20	911-930	
41. Another employer state	2	931-932	
41. Another employer zip	6	933-938	* (see note below)
41. Another employer zip ext	4	939-942	

Field Name	Length of Field	Position of Field	Contents
Claim Information			
42. Date of Injury or illness	8	943-950	
42. Date employer notified of injury/ Illness	8	951-958	
43. Incapacity Date	8	959-966	
43. Date employer notified of Incapacity	8	967-974	
44. Time employee began work	4	975-978	*military time
45. Date Employer Notified Insurer	8	979-986	
46. Time of injury	4	987-990	*military time
47. Has employee returned to work?	1	991	*(Yes-y, No-n, N/A-blank)
47. Date returned to work	8	992-999	
48. Specific Injury	50	1000-1049	
49. Body Part Affected	50	1050-1099	
50. Objects used in injury event	50	1100-1149	
51. Specific Activity	50	1150-1199	
51. Specific Activity part of normal duties?	1	1200	
52. Injury Events	250	1201-1450	

Field Name	Length of Field	Position of Field		Contents
Healthcare Information				
53. Hospitalized Overnight?	1	1451		
55. Health care provider name	36	1452-1487		
55. Healthcare provider name2	36	1488-1523		
56. Healthcare Addr1	24	1524-1547		
56. Healthcare Addr2	24	1548-1571		
56. Healthcare City	20	1472-1591		
56. Healthcare state	2	1592-1593		
56. Healthcare zip	6	1594-1599		* (see note below)
56. Healthcare zip ext	4	1600-1603		
57. Healthcare telephone	10	1604-1613		
Preparer Information				
58. Preparer Name	29	1614-1642		
58. Preparer Title	30	1643-1672		
59. Preparer Telephone	10	1673-1682		
59. Date sent to WCB	8	1683-1690		
Jurisdiction (edi only)	2	1691-1692		"ME"
60. Employer Site Number	5	1693-1697		* (see below)
61. Report Only	1	1698	**	(Yes-y, No-n or blank)
Claim Administrator Information (EDI Only - not on paper form) **				
Claim Administrator Name	40	1699-1738		
Claim Administrator FEIN	9	1739-1747		
Claim Admin Mailing Information Attn Line	50	1748-1797		
Claim Admin Mailing Primary Address	40	1798-1837		
Claim Admin Mailing Secondary Address	40	1838-1877		
Claim Admin Mailing City	15	1878-1892		
Claim Admin Mailing State	2	1893-1894		
Claim Admin Mailing Postal Code	9	1895-1903		

TRAILER RECORD – one record for each transmission

Field Name	Length of Field	Position of Field	Contents
Record Type	3	1-3	"TR1"
Record Count	9	4-12	total number of records transmitted

Please Note :
*
- All logical Yes/No fields should be entered as either y or n (blank = no except in pos 10 & 47). Positions 10 and 47, a blank/null character means N/A
- Dates are 2 digit month, 2 digit day, 4 digit year (mmddyyyy)
- Telephone numbers are : area code plus 7 digit number (2079895093)
- Money amounts should have no decimal points, and no commas (10020 is 100 dollars and 20 cents)

- Zip codes are 6 characters long to accommodate Canadian codes. Zero fill first position for US zips (ex 04333 should be sent as 004333)
- Employer site number (1693 – 1697) should be blank if unknown, 00000 is a valid site location. WCB can provide list of assigned site numbers for each known physical location.
- Leave blank for all unknown information.

** Designates latest change