

Department Of Industrial Accidents

Information Technology

HOW TO – Submit a form 101 online

1. Log in to CMS with your username/password
2. Click 'Expand' (red button) under the Application menu tree
3. Click on the 'On Line Forms Submitted By Public' menu item.
4. You are then redirected to the online forms menu page.

The screenshot shows a web browser window titled "Massachusetts Department of Industrial Accidents - Online Forms". The address bar shows the URL: <https://daboapp-test.da.state.ma.us/pls/htmldb/f?p=999:1:3869351660608305>. The page content includes:

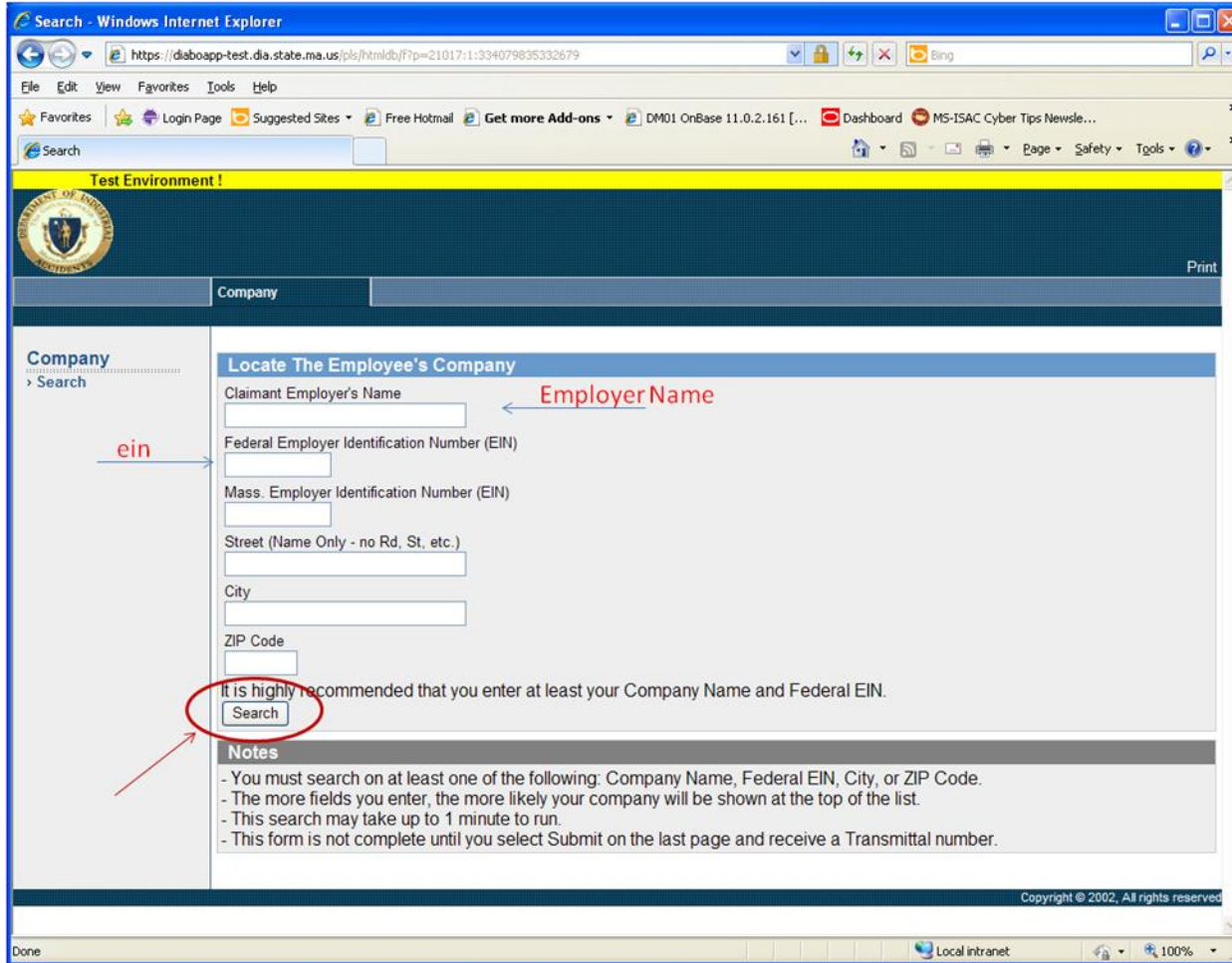
- Massachusetts Department of Industrial Accidents - Online Forms**
- Select a Form**
- General Instructions:**
 - Please note to add the **transmittal#** and **Board#** if known to every attachment or supporting document filed with the form. Supporting documents can be sent via facsimile to 617-727-4551.
 - Please Note: Filing DIA forms online does not fulfill your obligation by statute to notify all necessary parties of this filing**
- The following list of forms can be submitted online.
- Step 1:** Select a Form by clicking on the radio button next to the form name.
 - Form 101 -- First Report Of Injury
 - Form 103 -- Insurer's Notification Of Payment
 - Form 104 -- Insurer's Notification Of Denial
 - Form 106NM -- Insurer's Notification Of Modification Of Weekly Compensation During Payment Without Prejudice Period
 - Form 106NT -- Insurer's Notification Of Termination Of Weekly Compensation During Payment Without Prejudice Period
 - Form 107GT -- Insurer's Notification Of General Termination Of Weekly Compensation
 - Form 107 RC/NM -- Insurer's Notification Of Resumption Or Modification Of Weekly Compensation
 - Form 108 -- Insurer's Complaint For Modification, Discontinuance Or Recoupement Of Compensation
 - Form 110 -- Employee Claim
 - Form 114 -- Notice Of Change/Appearance Of Counsel
 - Form 114 -- Review Board Notice Of Change/Appearance Of Counsel
 - Form 115TPC -- Third Party Claim
 - Form 115TPL -- Third Party Notice Of Lien
 - Form 116 -- Request For Lump Sum Conference
- Query a Claim for the selected Form**
- Step 2 (Optional):** To query a claim for the form selected, please enter last name of the Employee and Board Number of the Claim. This will save data entry time by automatically bringing all the required data to the screen.
- Note:** Last Name and Board# or Last Name and SSN are required for **Third Party Notice of Lien (115TPL)** and **Notice of Change/Appearance of Counsel (Form 114)**
- Note:** Last Name and Board# or Last Name and SSN will be ignored for **First Report of Injury (101)**
- Board#
- Employee Last Name OR SSN

At the bottom of the page, it says "User: YAFAR Language: en-US" and "Copyright © 2004. All rights reserved." The browser status bar shows "Done" and "Local Intranet".

5. Choose Form 101 – First Report of Injury and press ‘Continue’.

In addition to the walkthrough in this document, please also refer to the instructions on the web pages.

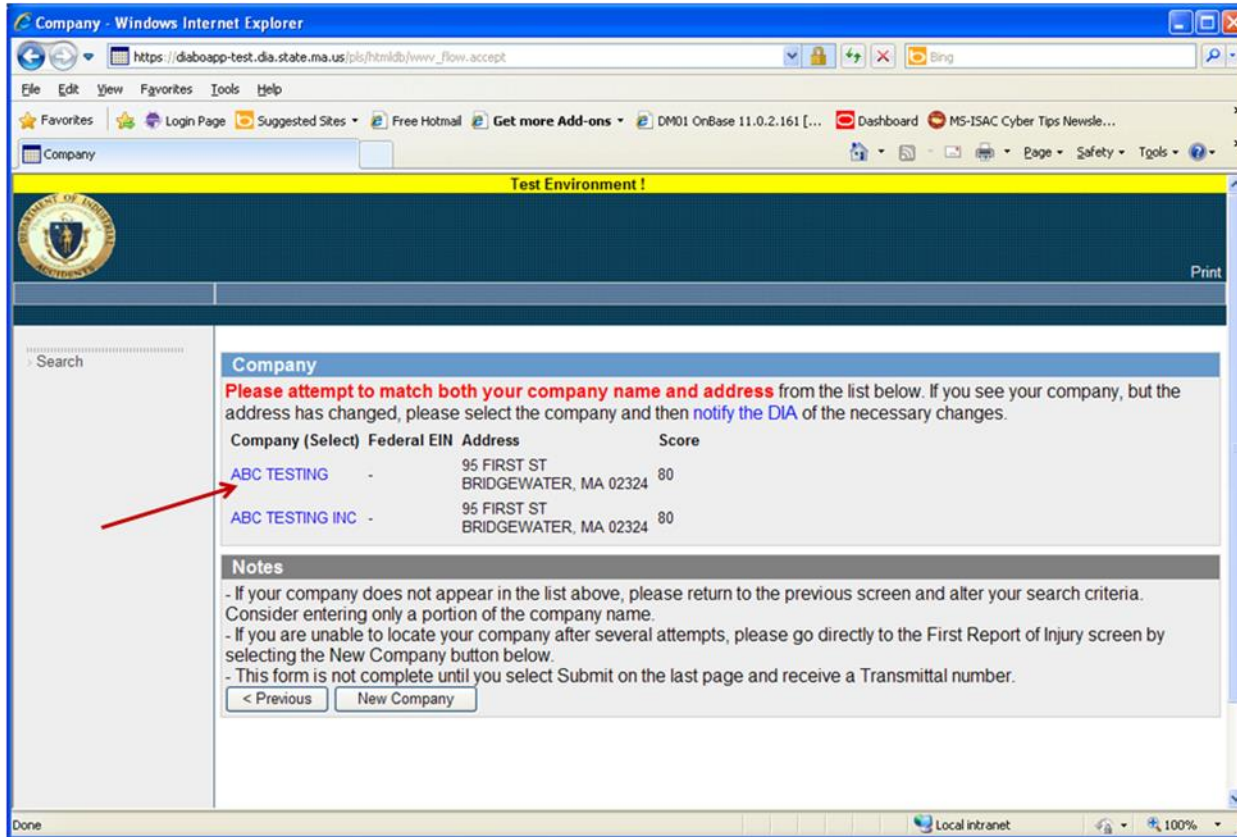
6. **Locate the employer** that you need to file the 101 for. You can either enter the EIN number or search by employer name. You can use wild card for a partial search. For example to locate ‘ACME building and construction Inc’ you can either enter ‘ACME’ or ‘ACME build%’ or ‘%ACME%’. Each search may retrieve a different result, if you cannot find the correct employer you might need to refine it.



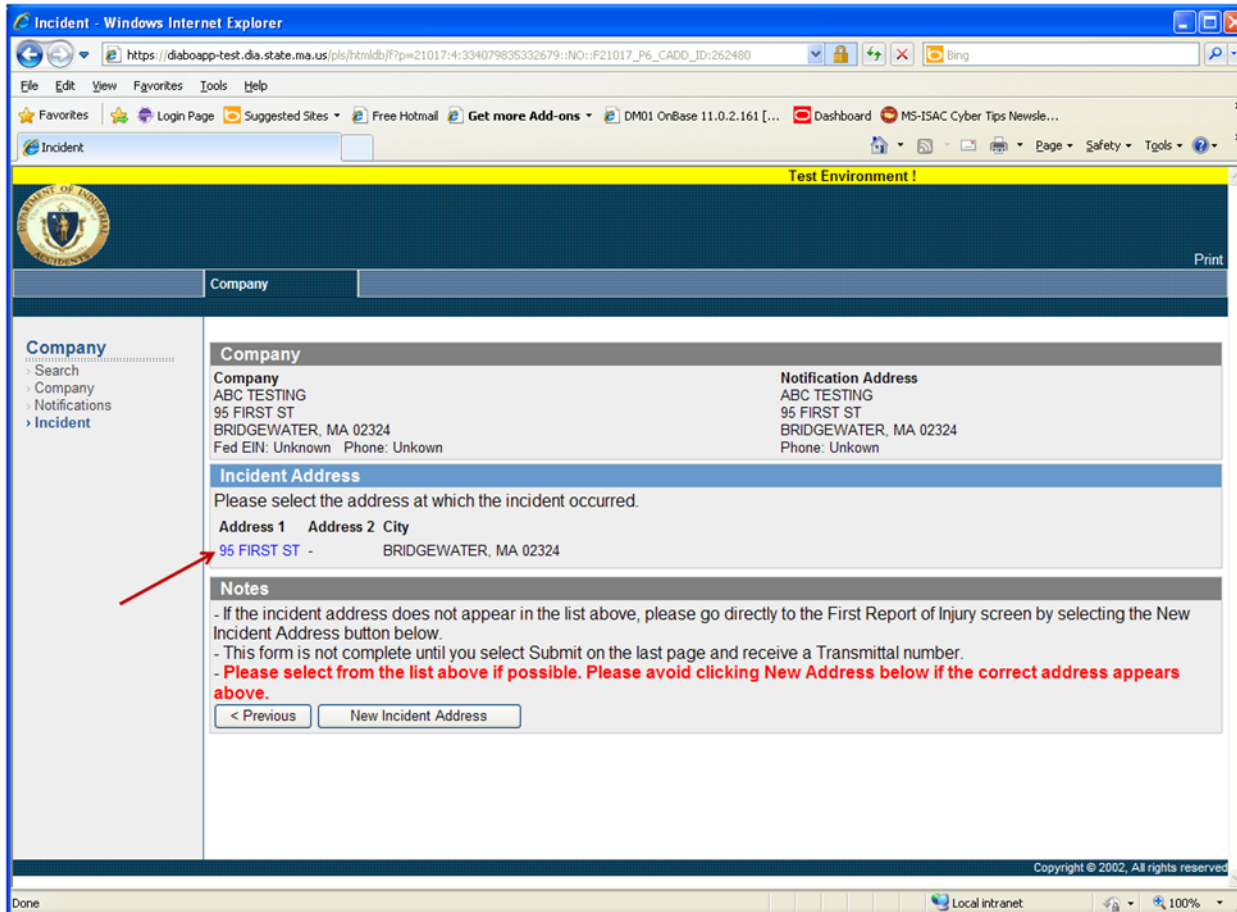
press ‘Search’ to retrieve the list of employers.

7. **Select a company from the result list that matches the employer by pressing the company name.**

If you cannot locate the employer after attempting multiple searches, you can press 'New Company'. You will be requested to enter the employer information at a later step. Please choose this option only after search attempts failed to locate your requested employer.



8. **Choose the incident address.** You may have more than one address to choose from. If you cannot locate an address where in the incident occurred on the list, you can press 'New Incident Address' you will be requested to add the new address at a later step.



9. **Enter the Employee information.** Required fields are marked with an *
press 'Next' when you're done.

The screenshot shows a web browser window titled "Employee - Windows Internet Explorer". The address bar contains the URL: https://diaboapp-test.dia.state.ma.us/pls/htmldb/F?p=21017:5:334079835332679::NO::F21017_P7_INJ_ADD_ID:262480. The browser's address bar shows "Employee".

The page header includes a yellow banner with the text "Test Environment!". Below this is a navigation bar with "Company" and "Form 101" tabs. A "Print" link is visible in the top right corner.

The main content area is titled "Employee" and contains the following form fields:

- * Employee's Name (First, MI, Last, Suffix) [Text input] [-Select-] [Dropdown]
- Home Telephone Number [Text input]
- Social Security Number [Text input]
- * Sex [Dropdown menu with "-Select-"]
- * Home Address [Text input]
- Home Address (Line 2) [Text input]
- * City [Text input]
- * State [Dropdown menu with "-Select-"]
- * ZIP Code [Text input]
- Marital Status [Dropdown menu with "-Select-"]
- No. of Dependents [Dropdown menu with "-Select-"]
- Native Language [Dropdown menu with "ENGLISH"]
- * Date of Hire (mm/dd/yyyy) [Text input]
- Date of Birth (mm/dd/yyyy) [Text input]
- * Average Weekly Wage [Text input] Actual Estimated

A "Next >" button is circled in red at the bottom of the form.

Below the form is a "Notes" section with the following text:

- This form is not complete until you select Submit on the last page and receive a Transmittal number.
- *Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

The footer of the page contains the text "Copyright © 2002, All rights reserved." and "Local intranet".

10. Select an insurer by clicking on the magnifying glass to the right of the insurer name field

The screenshot shows a web browser window titled "Employer - Windows Internet Explorer" with the URL https://diaboapp-test.dia.state.ma.us/pls/htmldb/www_flow.accept. The page is for "Form 101" and is in a "Test Environment".

Form 101
Employee
Employer


Employer (Pre-Selected)
ABC TESTING
95 FIRST ST
BRIDGEWATER, MA 02324
Fed EIN: Unknown Phone: Unkown

The above information is based upon information previously supplied. If this information is incorrect please notify the [Claims Department at the DIA](#).

Address (Pre-Selected)
ABC TESTING
95 FIRST ST
BRIDGEWATER, MA 02324
Phone: Unkown

The above information is based upon information previously supplied.

Insurance Information

* Worker's Compensation Insurance Carrier (Please click on  to select a carrier)

W.C. Policy Number Insurer's Case File Number

* Self-Insured? No If Yes, Self-Insurer Number Yes

Notes
- This form is not complete until you select Submit on the last page and receive a Transmittal number.

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Done Local intranet 100%

A new POP UP window will display, search for the appropriate insurer and select it. Use the 'Name' field to narrow the list.

Enter to locate the Insurer. You can use Wild card

Press when done

Search Company - Windows Internet Explorer

Search Items

Name %common% Search

Company List

Cancel

Name

- Select 21ST CENTURY ADVANTAGE INSURANCE CO
- Select 21ST CENTURY ASSURANCE CO
- Select 21ST CENTURY PACIFIC INSURANCE CO
- Select A AND P TEA CO
- Select A W CHESTERTON COMPANY
- Select ABC MASS WORKERS COMP SIG
- Select ABF FREIGHT SYSTEM INC
- Select ACADIA INSURANCE COMPANY
- Select ACCIDENT FUND GENERAL INS
- Select ACCIDENT FUND INS CO OF AMERICA
- Select ACCIDENT FUND NATIONAL INS
- Select ACE AMERICAN INSURANCE COMPANY

row(s) 1 - 12 of more than 500 Next >

the list will retrieve insurers that match the name you entered

The screenshot shows a web browser window titled "Search Company - Windows Internet Explorer". The page has a "Search Items" section with a text input field containing "%common%" and a "Search" button. Below this is a "Company List" section with a "Cancel" button. The list contains two entries:

Name	
Select	COMMONWEALTH OF MASS
Select	COMMONWEALTH TRANSPORTATION SIG

At the bottom right of the list, there is a "1 - 2" indicator. A red circle highlights the "Select" link for the first entry, with an arrow pointing to a text box that reads: "Click the 'Select' to the left of the required insurer".

After pressing 'Select', the insurer name will be populated in the insurer field.

Fill in the other fields accordingly for other information you may have and press 'Next'

The screenshot shows a web browser window titled "Employer - Windows Internet Explorer". The address bar shows the URL: https://diaboapp-test.dia.state.ma.us/pls/htmldb/www_flow.accept. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The address bar also shows a search engine icon for Bing.

The page content includes a yellow banner that says "Test Environment!". Below this is a navigation bar with "Company" and "Form 101" tabs. The main content area is titled "Form 101" and has a sidebar with "Employee" and "Employer" options. The "Employer" section is active and displays the following information:

Employer (Pre-Selected)
ABC TESTING
95 FIRST ST
BRIDGEWATER, MA 02324
Fed EIN: Unknown Phone: Unkown

The above information is based upon information previously supplied. If this information is incorrect please notify the [Claims Department at the DIA](#).

Address (Pre-Selected)
ABC TESTING
95 FIRST ST
BRIDGEWATER, MA 02324
Phone: Unkown

The above information is based upon information previously supplied.

Insurance Information

* Worker's Compensation Insurance Carrier (Please click on to select a carrier)
COMMONWEALTH OF MASS

W.C. Policy Number Insurer's Case File Number

* Self-Insured? No Yes If Yes, Self-Insurer Number

Next >

Notes
- This form is not complete until you select Submit on the last page and receive a Transmittal number.

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11. Fill in the Incident Information. Required fields are marked with an *

Click on the icons to the right of the Body Parts and Nature of Injury and a pop up will display for selection.

Also if you pressed new company/new address/new incident address previously this is where you will have to fill these fields.

Form 101

Injury Dates

- * Date of Injury
- * FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy)
- FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy)
- If Employee has Died, Date of Death (mm/dd/yyyy)

Location of Injury (Pre-selected)

95 FIRST ST
BRIDGEWATER, MA 02324
Phone: Unkown










Injury Information

- * Was Employee injured on Employer's Premises?
 Yes No
- * Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved

Person to Whom Injury was Reported (First Name, Last Name) _____ Position of Person Reported to _____

- * Date Reported (mm/dd/yyyy)
- * Date Reported as work related (mm/dd/yyyy)

For the items below, select the list of values icon for a list of available codes.

* Nature of Injury/illness	* Body Part Affected	Source of Injury
a. <input type="text"/> 	<input type="text"/> 	<input type="text"/> 
b. <input type="text"/> 	<input type="text"/> 	<input type="text"/> 
c. <input type="text"/> 	<input type="text"/> 	<input type="text"/> 

12. Press 'Next' at the bottom of the page when completing this page

The screenshot shows a web browser window titled "Injury - Windows Internet Explorer". The address bar shows the URL "https://disoapp-test.dia.state.ma.us/dia/html/db/www_flow_accept". The browser's menu bar includes "File", "Edit", "View", "Favorites", "Tools", and "Help". The toolbar contains "Favorites", "Login Page", "Suggested Sites", "Free Hotmail", "Get more Add-ons", "DM01 OnBase 11.0.2.161 [...]", "Dashboard", "MS-ISAC Cyber Tips Newsle...", and "ITD Eo504 Compliance Appl...".

The main content area is titled "injury information" and contains the following fields and controls:

- Was Employee Injured on Employer's Premises?
 Yes No
- Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved
- Person to Whom Injury was Reported (First Name, Last Name) Position of Person Reported to
- Date Reported (mm/dd/yyyy) Date Reported as work related (mm/dd/yyyy)
- For the items below, select the list of values icon for a list of available codes.
- Nature of Injury/Illness: a. b. c. d. e. f. g.
- Body Part Affected:
- Source of Injury:
- Witness(es) to Injury - Give Full Name(s), if NONE state as such
- Has Employee Returned to Work? Yes No Date Employee Returned to Work (mm/dd/yyyy)
- Employee's Regular Occupation Has Employee Returned to Regular Occupation? Yes No

A "Next >" button is circled in red at the bottom left of the form area. Below the form is a "Notes" section with the text: "This form is not complete until you select Submit on the last page and receive a Transmittal number." The browser's status bar at the bottom shows "Local intranet" and "100%".

13. Please review the information entered and sign below. If you need to correct any of the information, use the links on the left to return to the appropriate section for correction.

Submission

File Edit View Favorites Tools Help

IBM Support Portal ITD - INTERCHANGE PROD ITD - Interchange TEST-QA Employment, Equal Acces...

Instructions Print

Company [View 101](#)

Employee
 JOHN DOE Home Phone: 617-333-1234
 Social Security Number: -- Sex: M

Employer
 ABC TESTING
 95 FIRST ST
 BRIDGEWATER, MA 02324
 Fed EIN: Unknown Phone: Unkown

Home Address:
 1 AVENUE BLVD
 BOSTON, MA 02111

Marital Status: Dependents: 0
 Native Language: ENGLISH
 Hire Date: 01/01/2000 Birth Date:
 Weekly Wage: 111 Estimated

Worker's Comp Insurer:
 COMMONWEALTH OF MASS
 Policy No.: Self Insured: N Number:
 Insurer's Case File Number:

Injury Information

Date of Injury: 01/01/2014
 FIRST day of Total or Partial Incapacity to Earn Wages: 01/01/2014
 FIFTH day of Total or Partial Incapacity to Earn Wages: 01/05/2014
 Date of Death:

Location of Injury:
 95 FIRST ST
 BRIDGEWATER, MA 02324
 Phone: Unkown
 Injured on Employer's Premises? Y

Description: ENTER INJURY DESCRIPTION

Injury Reported To:
 Date Reported: 01/01/2014 Date Reported Work Related: 01/01/2014

Nature of Injury/Illness	Body Part Affected	Source of Injury
152	110	

Witnesses: WITNESS 1 AND WITNESS 2

100%

14. Enter your information and press Submit to conclude.

Submission - Windows Internet Explorer
https://diaboapp-test.dia.state.ma.us/.../html/flow_accept

COMMONWEALTH OF MASS
Policy No.: Self Insured: N Number:
Insurer's Case File Number:

Injury Information

Date of Injury: 01/01/2014
FIRST day of Total or Partial Incapacity to Earn Wages: 01/01/2014
FIFTH day of Total or Partial Incapacity to Earn Wages: 01/05/2014
Date of Death:

Location of Injury:
95 FIRST ST
BRIDGEWATER, MA 02324
Phone: Unkown
Injured on Employer's Premises? Y

Description: ENTER INJURY DESCRIPTION

Injury Reported To:
Date Reported: 01/01/2014 Date Reported Work Related: 01/01/2014

Nature of Injury/Illness	Body Part Affected	Source of Injury
152	110	

Witnesses: WITNESS 1 AND WITNESS 2

Has Employee Returned to Work? N Date Returned:

Employee's Regular Occupation: ENTER OCCUPATION Has Employee Returned to Regular Occupation? N

Submission

This form must be filed by the employer or an authorized agent/representative of the employer.

* EMPLOYER'S Name (First Name, MI, Last Name) * Title
* Preparer's Email Address * Are you the employer or an authorized representative?
 Yes No

Notes

- This form is not complete until you select Submit and receive a Transmittal number.
- If any information above is incorrect, please use the links at the left to return to the appropriate sections.

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15. You should receive a **DIA Transmittal number** for your records. Keep this number for future reference or until you are assigned a DIA Board Number. You may print a copy for your records by selecting the 'Print' on the upper right corner. Follow the instruction for submitting another form or returning to the DIA Application Tree.

In case a transmittal number is not provided - the form has not been received by the department.

https://disboapp-test.dia.state.ma.us/pls/htmldb/www_flow.accept

Form 101

Test Environment!

Form 101 Submitted

Click for a copy

Instructions Print

Actions

- **DO NOT USE YOUR BROWSER'S BACK BUTTON**
- To print this form, please select print at the upper right, a new window will open, use your browser's print feature and press 'Close' when done.
- To create a new incident for a different company, select Clear All.
- To create a new incident for the same company, select New Incident.
- To duplicate this incident for a different employee, select Duplicate Incident.

Clear All New Incident Duplicate Incident Return to DIA Home Page

Substitute Form 101

Your Transmittal Number is **153517**

Employee	Employer
JOHN DOE Home Phone: 617-333-1234 Social Security Number: -- Sex: M	ABC TESTING 95 FIRST ST BRIDGEWATER, MA 02324 Fed EIN: Unknown Phone: Unkown
Home Address: 1 AVENUE BLVD BOSTON, MA 02111	Worker's Comp Insurer: COMMONWEALTH OF MASS Policy No.: Self Insured: N Number: Insurer's Case File Number:
Marital Status: Dependents: 0 Native Language: ENGLISH Hire Date: 01/01/2000 Birth Date: Weekly Wage: 111 Estimated	
Injury Information	
Date of Injury: 01/01/2014 FIRST day of Total or Partial Incapacity to Earn Wages: 01/01/2014 FIFTH day of Total or Partial Incapacity to Earn Wages: 01/05/2014 Date of Death:	Location of Injury: 95 FIRST ST BRIDGEWATER, MA 02324 Phone: Unkown Injured on Employer's Premises? Y

Follow Instructions To continue