FORM 110-A

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 110-A
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7306 in Mass. / Outside Mass. - 617-727-4900 ext. 7306
http://www.mass.gov/dia

DIA Board # (If Known):

EMPLOYEE'S CLAIM FOR POST-LUMP SUM MEDICAL MEDIATION

FOR USE BY EMPLOYEES SEEKING POST-LUMP SUM MEDICAL MEDIATION ONLY.

EMPLOYEE

1. Employee's Name (Last, First, Middle):	2. Social Security number*:	3. Home Telephone No.:	4. Date of Birth:
5. Home Address (No., Street, City, State & Zip Code):		6. Employee's E-mail address (if available):	
7. Name, Address and BBO# of Employee's Attorney (if no attorney, leave blank)**:			
8. Attorney's E-mail address (Required):		8a. Attorney's Telephone No.:	

EMPLOYER

9. Employer's Name & Address (No., Street, City, State & Zip Code):
10. Workers' Compensation Insurance Carrier's Address and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):

INJURY BENEFITS CLAIMED

11. DATE OF INJURY (mm/dd/yyyy):	12. L/S Date (mm/dd/yyyy):	13. Insurer's Case/Claim #:
14. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	15. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	

16. REQUIRED:
Please provide a written explanation as to why the employee is seeking medical mediation.

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REQUIRED:
Please check all boxes that apply:

- ☐ Insurer's Denial of Medical Treatment
- ☐ Insurer's Denial of Prescription Medication
- ☐ Prescription Attached
- ☐ Medical Note/Report
- ☐ Affidavit of Insurer's Denial

17. Name and Address of Treating Physician:	18. Last Treatment (mm/dd/yyyy):
19. Employee's/Claimant's Signature:	20. Date (mm/dd/yyyy):
21. Attorney's Signature (if applicable):	22. Date (mm/dd/yyyy):

***Disclosure of Social Security number is voluntary. It will aid in the processing of your claim.**
****Representation by an attorney is not required.**