

# WORKERS' COMPENSATION

## WEB REPORTING



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# ACCESSING NETCLAIM LOGIN VIA RISX-FACS.COM

NAVIGATE TO:  
[WWW.RISXFACS.COM](http://WWW.RISXFACS.COM)

Enter User ID

Enter Password

Remember Me

NEXT

SIGN IN

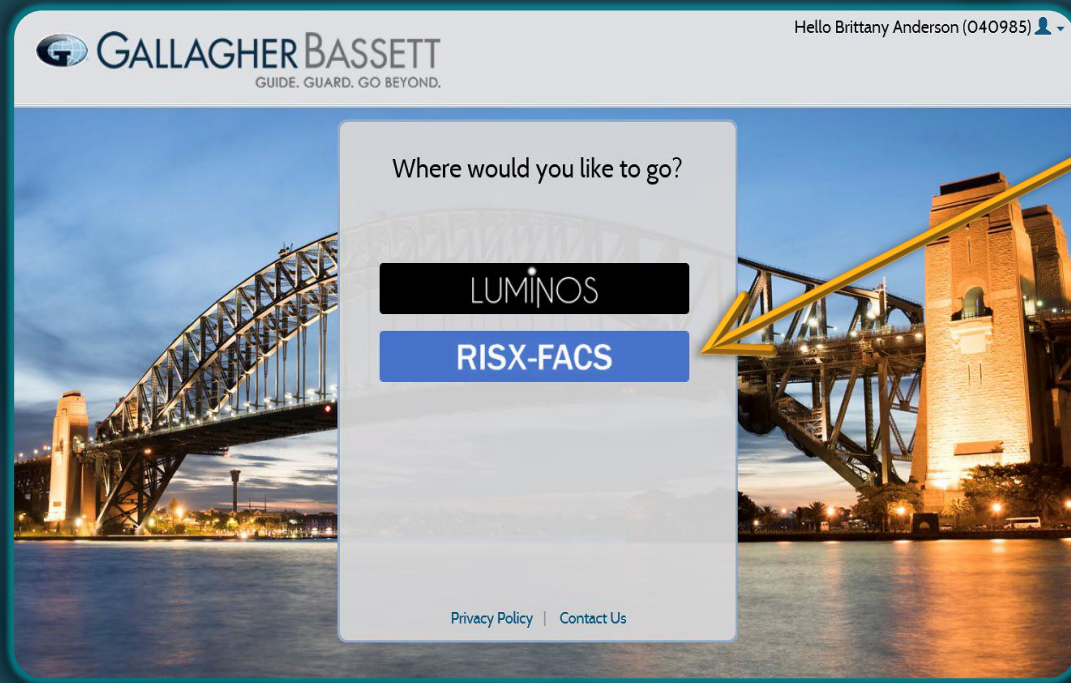
Forgot Password?

Enter your Risk-Facs User ID and Password.

If applicable, click **Forgot Password** to get a new password by email.

# ACCESS NETCLAIM

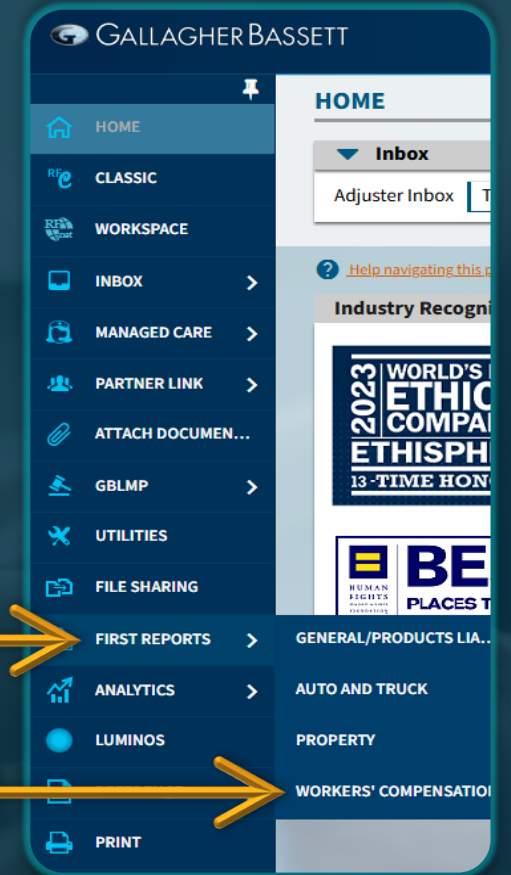
## NAVIGATING TO NETCLAIM FROM RISX-FACS



After logging in, select  
**Risx-Facs.**

This will open the Risx-Facs home page with a navigation menu on the left side of the page.

Open the dropdown menu for **First Reports** and select **Workers' Compensation**



This will open the **NetClaim** Landing Page in a new window.  
(Make sure pop-ups are enabled).

# NETCLAIM – START A NEW INCIDENT



Corporate

FAQ

Dialing Options

## Worker's Compensation Reporting

*The First Report of Injury or Illness provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process.*



Options for Reporting a **Worker's Compensation** claim:  
submit WC claim via the web  
call 1-800-333-3333



Click on **submit WC claim via the web**

# NETCLAIM – INCIDENT INFO

cancel save progress

**\* Required Fields**

**Your Information**

First	Last *	
<input type="text"/>	<input type="text"/>	
Title	Phone	Ext
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Incident Details**

Incident Date *	Employer Notified
<input type="text"/>	<input type="text"/>

Incident Description \*

## Incident Info Tab

- Enter as much information as possible.
- Any field with a red asterix \* is a required field.

# NETCLAIM – INCIDENT INFO CONTINUE

## Location Information

Location Info \*

[Enter your location](#)

Country \*

UNITED STATES

State \*

ILLINOIS

City \*

Rolling Meadows

Location \*

(1002) GB Demo Client Location 2 - 2850 Golf Road

Did the incident occur at the client location? \* yes  no

## Incident Location

Location Name

Address

City

State

Zip

County

Country

## Location Info:

This is the location the Employee reports to.

- First select the country
- Second Select the state
- Third Select the city
- Lastly, select the reporting location.
- If the location cannot be found in the drop down, click Enter your Location to manually enter it. This should only be used if the location is not found.

## Incident Location:

If the incident did not occur at the reporting location , click no and enter the name and address of the location it occurred.

# NETCLAIM – EMPLOYEE INFO

1. Incident Info   2. Employee Info   3. Witness Info   4. Additional Info   5. Final Review

cancel save progress

**\* Required Fields**

### Claimant

First Name *	Middle Initial	Last Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>

County	Country	Best contact phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

SSN	Gender	Marital Status	Number of Dependents
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth	Date of Death
<input type="text"/>	<input type="text"/>

### Supervisor

First Name	Middle Initial	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Title	Phone	Ext
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email

- Enter as much information as possible.
- The fields with a red asterisk are required.

# NETCLAIM EMPLOYEE INFO – CONTINUED

**Lost Time**

Lost Time  Salary Continued  Receive Full Wage

Return to Work Date  Last Date Worked

**Employment**

Job Title  Status  Full-Time/Part-Time

Hire Date  Termination Date

Wage  Frequency

**Work Schedule**

Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

**Injury Info**

Body Part \*

Cause \*

Nature \*

Medical treatment sought? yes  no

- **Injury info:**
  - Body Part, Cause and Nature: select the option that best fits the facts of the loss.
  - If medical treatment was sought, click yes.
  - You will then be prompted to enter hospital and/or doctor information

# NETCLAIM – WITNESS INFO

1. Incident Info 2. Employee Info 3. Witness Info 4. Additional Info 5. Final Review

cancel save progress

\* Required Fields

**Witness Info**

First Name	Last Name	Best contact phone
No witnesses have been added		

[add witness](#)

Previous Next

Click "add witness" if there were any witnesses to the incident

Enter the witnesses first name, last name and phone number. Click save witness. If another witness needs to be added click add witness and follow the same steps

1. Incident Info 2. Employee Info 3. Witness Info 4. Additional Info 5. Final Review

cancel save progress

\* Required Fields

**Witness Info**

First Name	Last Name	Best contact phone
No witnesses have been added		

**Witnesses**

First Name	Last Name
<input type="text"/>	<input type="text"/>
Best contact phone	Ext
<input type="text"/>	<input type="text"/>

[cancel](#) [save witness](#)

Previous Next

# ADDITIONAL INFO

cancel save progress

\* Required Fields

**SMS Text Dissem Contact Information**

Would you like to receive a text message detailing loss number and branch information for this incident?

**Additional State Information**

For which state are payroll taxes withheld for the employee?

Note to CS: If Caller is unsure of the answer  
Advise Caller that it may be the state of hire  
OR What is the employer's location state  
OR If the state of employment differs from where the state income taxes are withheld, it would be the state the employer considers the employee's place of work.

**Additional Information**

What is the claimant's cell number?

Please provide the employee's email address if available

Type of medical treatment

- This tab will be customized to your program. The questions here will differ slightly from what you see here.

# ADDITIONAL INFO – CONTINUED

**Notes**

Notes/Additional Comments

**Additional Escalation Criteria**

Does this claim meet any escalation criteria below?

Acts of Violence, with serious injuries

Assaults / Shootings, with serious injuries

Catastrophic losses involving 2 or more individuals

Burns - 2nd or 3rd degree over 25% or more of the body

Cardiac Arrest / Heart Attack / Myocardial Infarction

Life-Threatening Injuries

Serious head or brain injuries (i.e. concussion with loss of Consciousness of 1 minute or more, skull fracture, swelling of the brain)

Serious Spinal injuries NOT strain sprain

**Filing State**

Filing State

Illinois

**Documents**

Attach any related files

Choose Files

Total file size of all attached files cannot exceed 17 MB

**Total file size of all attached files cannot exceed 17 MB**

## Documents:

You may attach documents related to this incident. The limit is 17 MB total. Please make sure the titles of the documents do not contain any special characters.

# FINAL REVIEW

cancel

1. Incident Info   2. Employee Info   3. Witness Info   4. Additional Info   5. Final Review

**Your Information** [Edit](#)

First  
Last test  
Title  
Phone  
Ext

**Incident Details** [Edit](#)

Incident Date 01/06/2025  
Employer Notified  
Incident Description test

**Location Information** [Edit](#)

*Location Info*

Country UNITED STATES  
State ILLINOIS  
City Rolling Meadows  
Location (1002) GB Demo Client Location 2 - 2850 Golf Road  
Did the incident occur at the client location? yes

On the final review tab, you have the opportunity to review the information you entered. If you find that something is incorrect or you need to add more, click **Edit** next to that section. The system will bring you back to that page to make any updates

# FINAL REVIEW – CONTINUED

**Notes** [Edit](#)

Notes/Additional Comments

**Additional Escalation Criteria** [Edit](#)

Does this claim meet any escalation criteria below?

**Filing State** [Edit](#)

Filing State IL

**Documents** [Edit](#)

Attach any related files

**Submit Incident**

**Previous**

Once all information has been entered, click Submit Incident to complete the report.

# NETCLAIM – FINAL SCREEN



Your report has been submitted. Information regarding this report will be forwarded to the appropriate people within your organization.  
Please make note of the report number provided below.

128297274

Default Next Step Message - Thank You

Thank you for your report.

[Return to Home Page](#)

The Final screen will contain the loss reference number. It will also contain the branch name, number and mailing address. Any supporting documents or updates to this loss after it has been submitted should be sent directly to the handling branch.

# NETCLAIM SUPPORT



For any questions regarding web reporting or for general inquiries, please contact:

[GB-Claimline@gbtpa.com](mailto:GB-Claimline@gbtpa.com)



# Thank You



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