FORM 110

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 110
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA Board # (If Known):

EMPLOYEE'S CLAIM

FOR USE BY EMPLOYEES OR DEPENDENTS CLAIMING BENEFITS AS A RESULT OF INJURY OR DEATH.
ALL OTHER CLAIMANTS SHOULD USE FORM 115

***IMPORTANT - INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Social Security Number*:	3. Home Telephone No.:	4. Date of Birth:	5. # of Dependents:

6. Home Address (No., Street, City, State & Zip Code):	7. Employee's E-mail address (if available):	7a . Employee's Native Language Code: _____

8. Name, Address and BBO# of Employee's Attorney (if no attorney leave blank)**:

9. Attorney's E-mail address (Required):	9a. Attorney's Telephone No.:

EMPLOYER

10. Employer's Name & Address (No., Street, City, State & Zip Code):	10a. Industry Code (See Reverse Side):

11. Workers' Compensation Insurance Carrier's Address and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR - See Instructions on reverse side):

INJURY INFORMATION

12. DATE OF INJURY (mm/dd/yyyy):	**12a. Insurer's Case/Claim #:**
13. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**14. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
15. If Employee has Died, Date of Death (mm/dd/yyyy):	16. Describe Injury (Lower Back..., leg..., arm... etc.):

17. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:

18. Name(s) of Witness(es):

17a. Injury Code(s) Body Part Code(s)
a. to body part a.
b. to body part b.
c. to body part c.

19. Employee's Regular Occupation:	20. Average Weekly Wage: $_____ ☐ Actual ☐ Estimated	21. Has Employee Returned to Work?: ☐ Yes ☐ No

22. Has the Insurer Made Any Payments On Your Claim? ☐ Yes ☐ No If Yes - Indicate Type of Benefits and Amounts (Medical Bills, Wages, etc.):
_____ in the amount of $_____

BENEFITS CLAIMED

23. Section(s) of Law Claimed. Check all appropriate boxes below and attach documentation as required by M.G.L. c 152, § 7G, §10(1) and 452 CMR 1.07.

a. Sec. 34 ☐ Total, Temporary Incapacity Comp. from (date): from _____ to _____ and
from _____ to _____

b. Sec. 35 ☐ Partial Incapacity Comp. from (date): from _____ to _____ and
from _____ to _____

c. Sec. 36 ☐ Specific Comp. in the Amount of $_____

d. Sec. 31 ☐ Survivor's Benefits **e.** Sec. 33 ☐ Burial Expenses **f.** Secs. 13 & 30 ☐ Medical Expenses **g.** ☐ Other (Specify Sec):_____

24. Name and Address of Facility Where Employee was First Treated:	25. Name of Treating Physician:
26. Employee's/Claimant's Signature:	**27. Date (mm/dd/yyyy):**
28. Attorney's Signature (if applicable):	29. 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 (see instructions on reverse side).**

EMPLOYEE'S CLAIM FILING INSTRUCTIONS

1. WHEN TO FILE: File this form if you have been injured on the job and your employer's workers' compensation insurer (the insurer) has **denied your initial claim** and/or is disputing any part of your claim and refuses to pay the compensation that you believe you are entitled. **Please fill out the form completely and accurately.** The Department of Industrial Accidents (DIA) is the agency that handles all disputed workers' compensation claims. **You do not need to be represented by an attorney in order to file a Form 110.** You may represent yourself in your claim. The term that applies to self representation is **PRO SE.** Initiating a claim PRO SE **does not** prevent you from getting an attorney later. **If you need assistance, please call 1-800-323-3249 inside Massachusetts, or (857) 321-2149 outside Massachusetts.**

2. WHERE TO FILE: The original form must be mailed to the DIA at the address shown on the front of the form. A copy must also be provided to the employer as well as the insurer. We recommend that the employee keep a third copy for their own records. When an employee is represented by counsel, this form must be sent via certified mail to the insurer. **Please be advised** - claims for compensation **must** be accompanied by proper documentation in accordance with M.G.L. c. 152, §7G & 452 CMR 1.07.

3. EMPLOYER'S REQUIREMENTS: The law requires that all employers in Massachusetts carry a valid workers' compensation insurance policy at all times for all of their employees in the event of an industrial injury. Also, the employer must provide the name and address of the workers' compensation insurer upon request of an employee. **If the employer refuses to provide this information or does not carry workers' compensation insurance, notify the DIA immediately.**

4. EMPLOYEE'S SIGNATURE & DATE IN BOXES 26 & 27: This form may be filed by the Employee or the Employee's Attorney (if applicable). However, in all cases the Employee must sign and date this form.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 04 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 Cape Verdean / 9 – Other

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandizing
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Officers

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia or Strangulation Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Opthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC**
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor, UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition ,Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)..,Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devises.

***UNS - UNSPECIFIED** ****NEC - NOT ELSEWHERE CLASSIFIED**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Industrial Accidents
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111-1750

WHEN/HOW TO FILL OUT THE EMPLOYEE CLAIM FORM (FORM 110)

WHEN TO FILL OUT THIS EMPLOYEE'S CLAIM FORM

This Employee Claim form should be completed whenever you believe you are not getting all of the workers' compensation benefits you are entitled to. The **ONLY** reason for completing this form is to request a **judicial proceeding** before and Administrative Judge to obtain workers' compensation benefits.

When submitting this form, REQUIRED DOCUMENTATION must be attached, as required by Mass. Law, 452 CMR 1.07. A list of requirements, and other information, is available on the DIA's website: www.mass.gov/dia. Employee Claim forms filed without the required documentation will be rejected. Essentially, you need to attach copies of any information that relates your injury to work, and what the injury (or injuries) is. There are four (4) levels in the process of settling your dispute within the Department of Industrial Accident (DIA).

LEVEL #1 – **CONCILIATION SESSION:** This is an informal meeting between you and your company's insurer. Results of conciliation WON'T be binding unless you agree to them. Even when you are satisfied that you are being paid everything required by law, you MAY get a notice to attend a conciliation that you DID NOT request. This means that either the insurance company thinks it is paying TOO MUCH and would like to REDUCE your benefits or STOP your benefits. These insurance company requests are called "Complaints to Reduce or Discontinue Compensation." Once again, conciliations CANNOT result in changes in compensation rates unless both parties agree.

LEVEL #2 – **CONFERENCE:** If your case is referred to an Administrative Judge by the conciliator, a CONFERENCE is scheduled. This conference is also informal, with discussion between parties. If the matter is NOT settled, the Judge will issue a temporary order indicating whether or not the insurer must pay you compensation. If you are not satisfied with the Judge's order you may appeal it within 14 days of the filing date of the decision. The insurance company also has the right to appeal.

LEVEL #3 – **HEARING:** If your case is appealed by the insurer OR yourself, it will go to the HEARING stage, where the Administrative Judge conducts a FORMAL hearing of all evidence. Hearings are like regular trials; witnesses are called and sworn in and testimony is taken by stenographers.

LEVEL # 4 – **REVIEW BOARD:** Whichever party loses at a hearing may APPEAL the Administrative Judge's decision to the REVIEW BOARD within 30 days. Three (3) Administrative Law Judges will examine the hearing transcripts. They may ask for oral arguments. The Review Board will reverse the previous decision ONLY if the decision was beyond the Administrative Judge's authority, conflicted with the law, or was without any justification.

HOW TO FILL OUT FORM 110

YOU SHOULD FILL IN AS MANY OF THE BOXES ON THIS FORM AS YOU CAN. HOWEVER, THOSE LISTED BELOW ARE PARTICULARLY IMPORTANT TO GETTING YOUR REQUEST PROCESSED QUICKLY BY THE DIA. IF YOU HAVE ANY QUESTIONS PLEASE CALL THE INFORMATION DESK ON THE TOLL-FREE HOTLINE (In Mass.) 1-800-323-3249 or (Outside Mass.) (857) 321-7470 MONDAY – FRIDAY 8:00 AM – 5:00 PM.

Box #1: Please print or type your full last name, first name and middle initial.

Box #2: Your 9 digit social security number. **Disclosing your number is purely voluntary, but will be helpful to the DIA in keeping your records separate from others with the same name.**

Box #3: Print or type your home telephone number.

Box #4: Please print or type your date of birth.

Box #5: Please print or type your number of dependents.

Box #6: Please print or type your FULL home address. This is important because ALL notices, orders and decisions regarding your case will be sent to this address.

Box #7: If you wish to, you may provide your e-mail address to us, but your notices will still go through the regular postal service mail.

Box #7a: If English is not your native language, please print your native language using the NATIVE LANGUAGE CODES located on the back of the form.

Box #10: Please print or type your employer's business name and address. If your company has more than one address, use the address of their business office.

Box 10a: Please try to determine from the INDUSTRY CODES on the back of the form your employer's type of business. IF you CANNOT, just print or type number 99.

Box #11: Please print or type your employer's workers' compensation insurance company. (NOT the insurance agent, but the name of the carrier that will be paying your benefits to you.) We cannot schedule a conciliation without this information. If your employer will not tell you the name of the insurer, call our Office of Insurance, 617-626-5480 or 617-626-5481.

Box #12: Please print or type the date that you believe that you were originally hurt on the job or became ill because of a work-related illness. Use the date your first got medical treatment, or the last day you worked if you are unsure of the exact date.

Box #12a: Please print or type the case number/claim number that your employer's workers' compensation insurance company assigned your claim.

Box #13: Please print or type the first day that you were incapable of earning full wages because of your injury or illness.

Box #14: Please print or type the fifth day that you were incapable of earning full wages because of your injury or illness.

Box #17a: Please print or type the nature of injury or illness and the body part that has been affected by your injury or illness, from the codes printed on the back of the form. You may have more than one injury or illness listed (e.g. – a. 300, b. 310, c. 210), but the type of injury or illness listed in a MUST match the body part listed in a, and so on.

Box #23: Please check the benefits that you are claiming are due to you under the law. Other sections of the law include Sec. 30 – Medical Bills; Sec. 28 – Willful Misconduct of Employer, and Sec. 7 – Penalties and Interest for late payments.

Box #26: Please sign this form.

Box #27: Please date this form.

Box #28: If you have an attorney, they may sign here, otherwise leave this box blank.

WHAT TO DO WITH THIS CLAIM FORM

You should make 2 copies of this form. Mail the original to:

Department of Industrial Accidents – Dept. 110
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111-1750

One (1) copy should be mailed to the insurance carrier, complete with copies of all supporting documentation you send to the DIA. You should keep one (1) copy for your records. You can send a copy of your employer, but you are not required to send them a copy, unless you are filing for double compensation under Sec. 28 (Willful Misconduct). **You must also attach documentation as required by 452 CMR 1.07.** This rule, and other information, is available on the DIA's website – www.mass.gov/dia

When the DIA received your form, a conciliation will be scheduled for you within a few weeks. This session will be held in the department office closest to your home.

Best wishes for a prompt and full recovery.

Revised: 7/2018

FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

Print Form

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: _____ Other:_____	6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	**20a. Insurer's Case/Claim File No.:**
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:	

28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	

PREPARER

37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER'S Title:	
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 7/2010 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.
2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.
3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.
4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

INDUSTRY CODES

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99 Non-classifiable Establishments

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Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
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275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
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990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)..,Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devises.

***UNS - UNSPECIFIED** ****NEC - NOT ELSEWHERE CLASSIFIED**