State Of Louisiana OFFICE OF RISK MANAGEMENT

sedgwick

REQUEST FOR CLAIM CAPTURE LOGIN

Purpose and Directions – For Authorized State Employees Only! Complete this form to report Workers Compensation or GL claims. Send completed form by email to SolaSecurityRequest@sedgwickcms.com **Your login name and initial password will be emailed to you within 3 business days. Do not share your login info. For login information or password resets please call 866-647-7610.**

Legal Notice - By applying for and using your assigned login credentials, you agree to not disclose the information presented on screens and in system generated reports to any other person without a clear need or right to know. Information within this system may be protected by Federal and State privacy laws. Before sharing any information about a specific claim, person, or event, check with your supervisor or the claims adjuster assigned to the claim.

Select the line of coverage:

Claim Capture – Internet Claim Reporting: ☐ for Reporting Workers Compensation Claims
☐ for Reporting GL Claims

Monthly Reports: Form is located on the Loss Analysis tab: http://laorm.com/analysis.html

Today's Date: _____ **First Name:** _____ **Last Name:** _____

Email Address: _____ **Job Title:** _____

Telephone Number: _____ **Address:** _____

Your Agency's ORM 4 Digit Location Code(s) – To view an agency location code listing, please visit http://laorm.com/documents/loccodes.pdf

List D location/s if you need access to all S and L locations under the D level.
List S location/s if you need access to all L locations under the S level.
Otherwise, list each L location you need access to.

D Location Level: _____ Department Name: _____
S Location Level: _____ Agency/Division Name: _____
L Location Level: _____ Agency/Division Name: _____

Additional locations needed: (attach a separate list if needed)

LEVEL (D,S,or L)	LOCATION CODE (4 DIGITS)	DEPARTMENT OR AGENCY/DIV NAME

Requested by @ _____
(Signature of Person Requesting Access)

Your Supervisor's Name: _____ **Email:** _____
Job Title: _____ **Telephone Number:** _____

Authorization: (system access must be approved by your agency's appointing authority) **"I verify that the above named individual is currently employed at the agency listed and I authorize this employee to report claims. I understand that should this person leave the agency or is assigned to another duty station, I am to email SOLAsecurityRequest@sedgwickcms.com within one working day of the employee's change in status."**

Authorized by @ _____
(Signature of Authorized Agency Representative)

This section reserved for security use

Verified by _____

Audited by _____ on _____

(22) GROUP - LA State Agencies General Access Level

ORM State Agency Version 2.9 (Valid as of 11/22/13)