AWCC Form 1

(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)

Attachment D

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #	
		PHONE #	
INDUSTRY CODE / EMPLOYER FEIN			

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN / POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: M MALE; F FEMALE; U UNKNOWN	MARITAL STATUS: U UNMARRIED SINGLE/DIVORCED; M MARRIED; S SEPARATED; K UNKNOWN	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City	State	Zip Code	
Child Support Obligation: ☐ Current ☐ Past Due	Payable to:			

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name		
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.
"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

MUNICIPAL EMPLOYEE'S REPORT OF ACCIDENT

Mail to: Municipal League Workers' Compensation Trust

P.O. Box 37

North Little Rock, AR 72115

To be completed by employee:

PERSONAL: Name: _____ (Last), _____ (First), _____ (Middle) Phone: _____ Birth Date: _____ (mm/dd/yyyy)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Marital Status: _____ Sex _____

EDUCATION: Check highest grade level completed. ☐☐☐☐☐☐☐☐ (1 2 3 4 5 6 7 8) High School ☐☐☐☐ (9 10 11 12) College ☐☐☐☐ (1 2 3 4)

Vocational Tech _____ Other _____

EMPLOYMENT: Present Employer _____ Job Title _____ WagesWk _____

Length of Employment _____ If less than 5 years with present employer, list employers of past 5 Years:

_____

ACCIDENT: Date of Accident _____ (mm/dd/yyyy) Time _____ Place _____

Describe fully how the accident happened _____

_____

Who did you report the accident to? _____ When? _____

Who witnessed the accident? _____

Who is your supervisor? _____

Injury: Nature and location of injury (describe part(s) of body): _____

_____

Name and address of Doctor(s) _____

Who selected Your Doctor? _____ Date of First Visit _____

1st day unable to work: _____ Are you still under doctor's treatment? _____

DISABILITY: How long does your doctor anticipate you will be off? _____

Are your wages continuing? _____ If so, from what source? _____

Regular wages _____ Sick Leave _____ Vacation _____

Have you ever collected compensation for a prior injury? ☐ yes ☐ no

If yes, give details _____

Have you ever had any other condition or injury involving this part of your body prior to this injury?

☐ yes ☐ no. If yes give details _____

_____

Name and Address of Family Physician _____

I _____, received this day, a copy (front and back) of the Arkansas Workers' Compensation Form AR-N.

_____ (Employee Signature) _____ (Date mm/dd/yyyy)

_____ (Witness) _____ (Witness)

Accident Investigation Report

To be completed by the Supervisor within 24 hours of the Accident/Injury.

Date of the Report: _____

Name & Title of Injured Employee: _____ Age: _____

Social Security #: _____ Department: _____

Date and time of injury: _____ AM/PM_____

Location Where Incident Occurred: _____

Nature of Injury/Property Damage: _____

_____

Object or equipment that inflicted the injury, if applicable? _____

Describe the Incident (What happened?): _____

_____

_____

Contributing Factors? _____

_____

Witnesses: _____

What action(s) are being taken, and by whom, to prevent recurrence of this type of injury in the future? _____

_____

Was the report to supervisor or first aid delayed? _____ Why? _____

Was medical treatment required? _____ Who administered the medical treatment? _____

Where was medical treatment administered? _____

What is the severity potential for lost time? High/Major_____ Medium/Serious_____ Low/Minor____

Probable Recurrence Rate: Frequent _____ Occasional _____ Rare _____

Supervisor's Signature: _____ Date: _____

Investigated by: _____ Date: _____

Reviewed by: _____ Date: _____

SFTY-003
11/02

Pharmacy First Fill Letter of Intent

Injured Employee:		Employee Social Security Number:	
Employee Phone:		Employee Date of Birth:	
Pharmacy Name:		Pharmacy Phone Number:	

Date of Injury:	
Description of Injury:	

Employer:	City of Russellville	State of Jurisdiction:	Arkansas
Employer Rep:	Tanessa Vaughn	Employer Rep Phone:	479-968-2098

Employer: **Arkansas Municipal League** has selected Preferred Medical to administer the prescription drug program for your injured employee's workers' compensation claim. Please complete the top portion of this Letter of Intent and present it to your injured employee when you receive first notice of the injury. **Please email** intake@thepreferredmedical.com **or fax 502-489-5045 a copy of this letter to Preferred Medical.**

Employee: Please present this Letter of Intent to a participating pharmacy. Preferred Medical provides an extensive network of pharmacies, both large and small and a full list of our network pharmacies are available on our website at www.thepreferredmedical.com. You may also contact Preferred Medical on their toll-free line at **888-586-4650 Option 1** for a list of local participating pharmacies.

This Letter of Intent is to be used for your **initial** medication fills only. This letter will provide your pharmacist electronic access to information regarding your eligibility for workers' compensation Rx benefits.

If your claim is accepted, in approximately ten business days you will receive a permanent Rx card from Preferred Medical.

Use of this Letter of Intent is limited to medications associated with your workers' compensation injury. The payer reserves the right to restrict or suspend the use of your benefits associated with this program at any time.

Pharmacist: Preferred Medical administers this workers' compensation prescription drug program through the ProCare Rx network. For immediate online billing information, contact Preferred Medical at **888-586-4650 Option 1**. *Please Note: You may be required to fax or email a copy of the Letter of Intent to 502-489-5045 for verification purposes.

Pharmacy processing steps:

1. Call Preferred Medical at **888-586-4650 Option 1** to obtain the Member ID Number.
2. Enter BIN number: **023237**
3. Enter Processor Control Number (PCN): **PMN**
4. Group Number: **PREF3000**
5. Enter the Member ID provided by Customer Service.
6. Enter Person Code **01**