Public Employee Claims Division

Workers' Compensation

Initial Procedures

COMPANY NURSE™
Because Accidents Happen™

INJURY HOTLINE

1-855-339-1893

Available 24 hours / 7 days a week

Registered Nurses
Nationwide Coverage
Translation Services
Medical referral to designated clinic or ER
Document the “Report of Injury”

The Benefits of Making the "Right Call" for Workplace Injuries

✓**The Right Time** - Employers respond to workplace injuries on the "Day of Injury"

✓**The Right Care** - Medical expertise at the time of injury results in the most appropriate and cost-effective level of care.

✓**The Right Results** - Reduction in lost time, overall claims cost, legible claims

If it is an EMERGENCY, seek treatment first!

Call Company Nurse after treatment to report the injury.

A call to the Company Nurse Hotline MUST be made to report the injury.

Simple Steps to Follow…

- **The injured employee should notify his/her supervisor immediately.**

- **If NO medical treatment is needed, complete only the Incident Report and retain in the employee's file. Do not call Company Nurse and do not send the report to the Public Employee Claims Division.**

- **Call the Company Nurse Injury Hotline WHEN medical treatment is needed.**

Simple Steps to follow…

- **Injured employee should call the Company Nurse Injury Hotline. If the injured employee cannot make the call, the supervisor should call.**

- **Company Nurse will gather all the appropriate information and make care recommendations.**

- **Company Nurse will fax the incident report to the designated treatment facility prior to the injured employee's visit.**

Claim Forms

- **The phone call to The Company Nurse Injury Hotline will generate the workers' compensation claim forms.**

- **Company Nurse will email the workers' compensation forms to the appropriate agency's contact person and to the Public Employee Claims Division within five minutes of a phone call being made to Company Nurse.**

Simple Steps to follow…

- **The agency's contact will need to print the forms.**

- **The supervisor and injured employee will need to review the forms, complete any blank forms and make appropriate changes. All the forms will need to be signed and sent to the Public Employee Claims Division in a timely manner.**

Forms attached in email:

* Company Nurse Report of Injury

* Workers' Compensation – First Report of Injury or Illness Form

* Form N – Employee's Notice of Injury

* Form N Acknowledgement Form

* Form PECD 1 – Employee's Report of Accident

* Form PECD 2 – Employer's Report of Accident

Claim Forms…

The completed forms need to be faxed to Public Employee Claims Division

501-371-2733

Example Forms

Sample –
pg. 1 of 3

Sent to Designated Treatment facility

COMPANY NURSE
Injury Hotline

Report of Injury

Confidential

Call Confirmation #HXP006NH Time : 12/07/2012 09:38:46 Jones , Angela

To: San Jacinto USD - Test Record Only
Primary Contact : Test Name
Phone : 999-999-8745
Alternate Contact : TEST RECORD
Employer Address : San Jacinto Unified School District 2045 S. San Jacinto Avenue
San Jacinto CA 92583

Re: Angela Jones

Dear Employer:

Please find attached an injury report for an incident which occured on 12/07/2012 07:30:00 .
The following information was provided to Company Nurse 0 days later on 12/07/2012 08:34:00.
Your employee was triaged by a nurse and will seek or has sought treatment.

Treatment facility:

Test Clinic
123 Main St
Any City AZ 85001
Phone : 480 222-0002 Fax : 623-321-1511

A Provider Alert has been faxed to the above number with the Employer's Name & Address, Employee's Name & Address, Details of the Injury, and a Work Status Report that the medical provider may complete and return to your designated recipient.

If your company mandates POST-ACCIDENT DRUG/ALCOHOL TESTING or if you have a RETURN-TO-WORK program and you have notified Company Nurse of these programs, we have included this information on the fax to the provider. If you would like more information on these services, please contact your Company Nurse Customer Service Representative or notify the main office at 888-817-9282 or service@companynurse.com.

Please contact the medical facility to obtain drug/alcohol test results and employee work limitations.

Claims/Medical Billing Information (if a treatment facility is populated above, we have forwarded this information to them):

Test Insurance
9512 Claims St Suite 1526
Phoenix AZ 85001
Phone : 666 666-6666 Fax : 666 666-6667

Home care/first aid advice provided by Company Nurse does not constitute authorization for modified duty.
This injury report is being forwarded as a service to your organization; you may want to further investigate the incident.

COMPANY NURSE Injury Hotline

Report of Injury

Confidential

Call Confirmation #HXP006NH Time : 12/07/2012 09:38:46 Jones , Angela

Employer Information

San Jacinto USD - Test Record Only TEST1 San Jacinto Unified School District 2045 S.... San Jacinto CA 92583 Phone : 999-999-8745	Location: Address of Business Location 2045 S. San Jacinto Avenue San Jacinto, CA 92583-4398 Report Taken By: Dorothy , Nicole

Employee Information

Last	First	Middle Initial	SSN	Date of Birth	Gender	Marital Status
Jones	Angela		000-22-5555	12/05/1959	F	Married

Home Address	City	State	Zip
1245 E Elm St	Rail Road Flat	CA	95248

Home Phone	Work Phone	Hire Date	Occupation	Avg Weekly Wage Data
949-231-6738	949-623-5795	11/01/2009	Food Service Worker	NOT PROVIDED

Caller	Supervisor Name	Supervisor Phone
Angela Jones	Russel Crow	949-623-5795

Language

Employee Speaks	Language Service Used
English	

Interpreter 1 ID #	Interpreter 2 ID #	Interpreter 3 ID #

Date, Time, and Place of Incident/Report

Date/Time (local) of Incident	Day of week	Date/Time (local) Reported to CN	Date/Time Reported to Supervisor	Injury Work Department
12/07/2012 07:30:00	Friday	12/07/2012 08:34:00	12/07/2012 07:40:00	Kitchen

Injury Location: 2045 S. San Jacinto Avenue San Jacinto 92583-4398 CA

Witnesses:
Jerry Smith

Injury and Treatment

Nature of Incident / body part
Cuts, Lacerations, Scrapes, Punctures Thumb Right

☐ Report Only NO TRIAGE
☐ Care Advice Given

Reason Alternate Chosen

Not on file Treatment Facility/Location

RN Triage

Medical Guideline	Nurse Override
SCRAPES, CUTS, & PUNCTURE WOUNDS	

Patient Response driving Medical Guideline
· puncture wound of undetermined depth? - Yes

☒ Patient Understands
☒ Patient Compliant

Patient Override

Patient Reason

Care Advice
3. See Physican within 4 hours - Occ Health / UC / Other
23. Clean cloth or clean paper towels over wound, no salves or ointments, may apply ice or heat to wound for comfort, maintain injured part in position of comfort, Neosporin Plus Pain Relief may be used

COMPANY NURSE Injury Hotline

Report of Injury

Confidential

Call Confirmation #HXP006NH Time : 12/07/2012 09:38:46 Jones , Angela

Triage Notes

1. Please describe your medical complaint.
Cut to right thumb.
2. How did the accident happen? (Please state all details)
Angela was slicing tomatoes for a salad when she cut her right thumb.
3. Please specify machine, tool, substance or object most closely connected with the accident.
Knife
4. What was the employee doing when accident occurred?
(i.e. loading truck, walking down stairs, etc)
Slicing tomatoes for a salad.
Medical History:
Last tetanus 5 years ago.
Other:
6. Essential Nursing Notes:
Right thumb cut deep, approximately 1 inch length. Oozing. Washed with water, advised to re-wash with soap.
Triaged to be seen. Agreed with the plan.

Sample Claim

pg. 1 of 6

Sent to Public Employee Claims Division and personnel specified by agency

Preparer's signature is WC Claims Specialist or WC Analyst in Public Employee Claims Division

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
San Jacinto USD
2045 S San Jacinto Ave
San Jacinto, CA 92583-4398

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG CASE # | REPORT PURPOSE CODE

JURISDICTION: Arkansas | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): Unified School District | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #: 999-999-8745

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)
Public Employee Claims Division
1200 West Third Street
Little Rock, AR 72201

POLICY PERIOD: TO

CHECK IF APPROPRIATE: ☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO): Same As Carrier

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE): Jones, Angela
DATE OF BIRTH: 12/05/1959
SOCIAL SECURITY NUMBER: 000-22-5555
DATE HIRED: 11/01/2009
STATE OF HIRE: AR

ADDRESS (INCL ZIP)
1245 E Elm St
Rail Road Flat, CA 75248

SEX: ☑ M MALE ☐ F FEMALE ☐ U UNKNOWN

MARITAL STATUS: ☑ U UNMARRIED SINGLE/DIVORCED ☐ M MARRIED ☐ S SEPARATED ☐ K UNKNOWN

OCCUPATION/JOB TITLE: Food Service Worker
EMPLOYMENT STATUS

PHONE: 949-231-6738
OF DEPENDENTS
NCCI CLASS CODE

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

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: 7:00 ☑ AM ☐ PM
DATE OF INJURY/ILLNESS: 12/7/2012
TIME OF OCCURRENCE: 7:30 ☑ AM ☐ PM ( ) CANNOT BE DETERMINED
LAST WORK DATE: 12/7/2012
DATE EMPLOYER NOTIFIED: 12/7/2012
DATE DISABILITY BEGAN: 12/7/2012

CONTACT NAME/PHONE NUMBER: Russel Crow 949-623-5795
TYPE OF INJURY/ILLNESS: Laceration
PART OF BODY AFFECTED: Right Thumb

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: Kitchen

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Knife

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Cutting tomatoes for a salad

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
Angela was slicing tomatoes for a salad when she cut her right thumb.

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)
Test Clinic
123 Main Street
Any City, AZ 85001
Phone: 480-222-0002

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Test Hospital
456 Main Street
Any City, AZ 85001
Phone: 480-222-0005

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 #)
Jerry Smith

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED: 12/7/2012 | PREPARER'S NAME & TITLE | PHONE NUMBER

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION ©IAIABC 2002

pg. 2 of 6 (two-sided)

Employee signature required on front and back side.

Make sure employee is given a copy of the front and back side of this form.

Form AR-N

Ark. Code Ann. §§11-9-711, 508, 510
AWCC Rule 099.33
Revised: 1-1-2001
Updated: 8-1-2006

ARKANSAS WORKERS' COMPENSATION COMMISSION

324 Spring Street, Little Rock, AR 72201
Mail: P. O. Box 950, Little Rock, AR 72203-0950
501-682-3930 / 1-800-622-4472

N

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

JONES	ANGELA		000-22-5555	949-231-6738
Employee's Last Name	First Name	M.I.	Social Security Number	Home Phone No.
1245 E. ELM ST	RAIL ROAD FLAT		CA	75248
Street Address or P.O. Box	City		State	Zip Code

Child Support Obligation: ❑ Current ❑ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

San Jacinto Unified School District	RUSSEL CROW		
Employer's Name	Supervisor's Name		
2045 S San Jacinto Ave	San Jacinto	CA	92583
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

KITCHEN	12/7/2012	7:30 AM	Date 12/7/2012 Time 7:30
Place of Accident	Date of Accident	Time of Accident	Employer Notified of Accident

What part of your body was injured? RIGHT THUMB

Briefly discuss the cause of injury: ANGELA WAS SLICING TOMATOES FOR A SALAD WHEN SHE CUT HER RIGHT THUMB

Name/address of witness(es): JERRY SMITH

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. §11-9-1066(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."

pg. 3 of 6 (back side)

Employee signature required on front and back side.

Make sure the employee is given a copy of the front and back side of this form.

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N

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 (e)]

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.

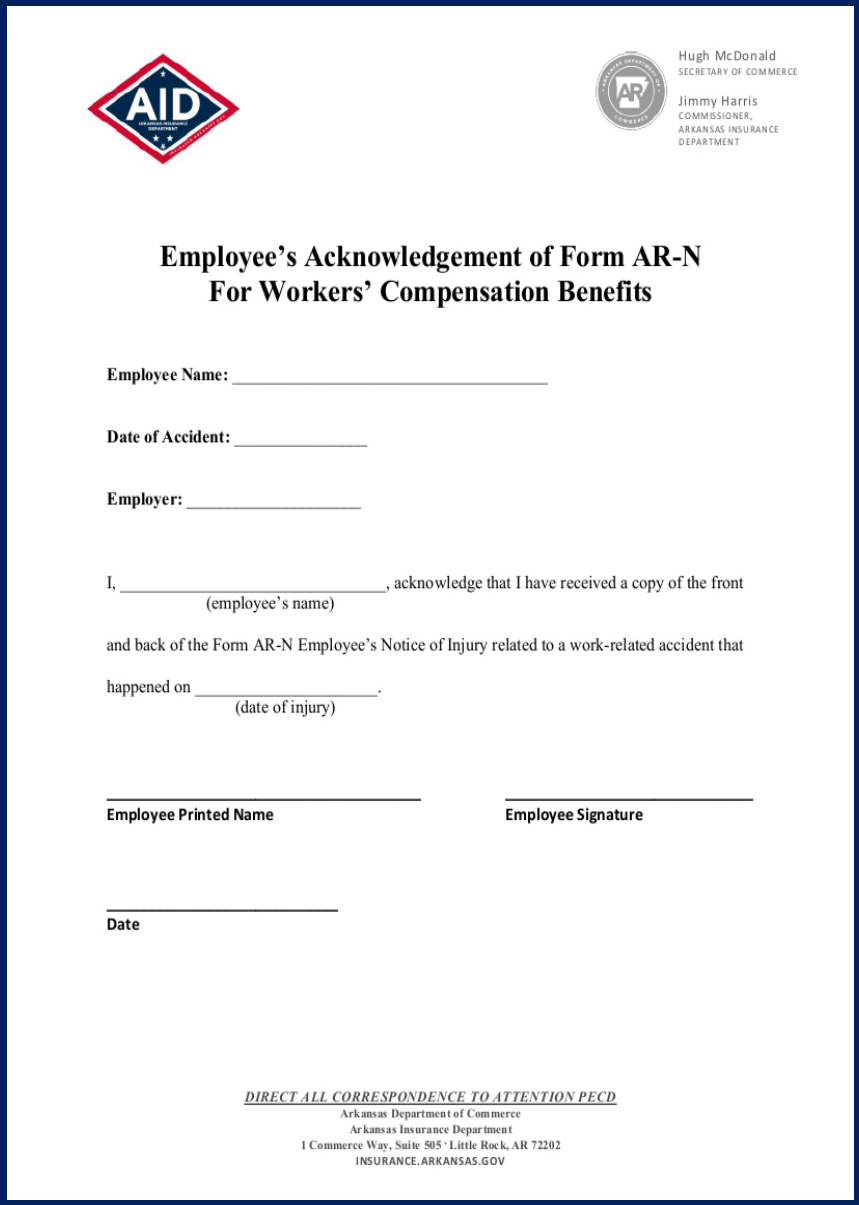
Back side / Two-sided form

N

Employees Signature Date

Form N Acknowledgement

Have the injured employee complete, sign and date this form to acknowledge receipt of the front and back of the Form N. Fax this with the completed initial claims forms.



Hugh McDonald
SECRETARY OF COMMERCE

Jimmy Harris
COMMISSIONER,
ARKANSAS INSURANCE DEPARTMENT

Employee's Acknowledgement of Form AR-N
For Workers' Compensation Benefits

Employee Name: _____

Date of Accident: _____

Employer: _____

I, _____, acknowledge that I have received a copy of the front
(employee's name)

and back of the Form AR-N Employee's Notice of Injury related to a work-related accident that happened on _____.
(date of injury)

_____ _____
Employee Printed Name **Employee Signature**

_____
Date

DIRECT ALL CORRESPONDENCE TO ATTENTION PECD
Arkansas Department of Commerce
Arkansas Insurance Department
1 Commerce Way, Suite 505 · Little Rock, AR 72202
INSURANCE.ARKANSAS.GOV

pg. 5 of 6

Employee signature required

v. 10/10/2011

FORM PECD 1
EMPLOYEE'S REPORT OF ACCIDENT

PUBLIC EMPLOYEE CLAIMS DIVISION
Arkansas Insurance Department
1200 West Third, Little Rock, Arkansas 72201-1904
Telephone 501-371-2700 Facsimile 501-371-2733

TO BE COMPLETED BY EMPLOYEE:

Name: Angela Jones Tel # 949-231-6738

Address: 1245 E Elm St

Birth Date: 12/05/1959 Marital Status: Unknown Spouse's Name: _____

Dependents Names and Ages: _____

Education (Circle highest level completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 5+

Present Employer: San Jacinto Unified School District

Job Title: Food Service Worker Length of Employment: _____

If less than 5 years, list employers of last 5 years: _____

Date of Accident: 12/7/2012 Time: 7:30 AM Place: PO Box 2376 Batesville, AR 72503

Describe activity of employment engaged in at time of injury: Slicing tomatoes for a salad

Describe how injury occurred: Angela was slicing tomatoes for a salad when she cut her right thumb

To whom did you report the injury: _____

When: 12/7/2012 Supervisor's Name: Russell Crow

Nature and location of injury (describe part of body): Laceration to right thumb

Doctor's Name: _____ Family Doctor's Name: _____

Who Selected Doctor? _____ Are you still under doctor's treatment? _____

Date of First Visit? _____ First Day Unable To Work? _____

Have you ever collected compensation for a prior injury? _____

If yes, give details: _____

Have you ever received medical or chiropractic treatment to this part of the body before (either as a workers' compensation or a non-workers' compensation injury)? ____ Yes ____ No. If yes, give details including date: _____

Do you have child support obligations? ___ Yes ____ No (Child support obligation questions are required by Ark. Law)

If yes, are the obligations current or past due? _____ Current or _____ Past Due

To whom are the child support obligations payable? _____

Are you enrolled in the Medicare Program? ____ Yes ____ No (Medicare question is required by federal law.)

Have you applied for Social Security Disability? __ Yes __ No Date Applied for Social Security _____

If you applied for social security disability, was your claim approved or denied? ___ Approved ___ Denied

Signed: _____ Date: _____

pg. 6 of 6

Supervisor signature required

PECD 2 FORM
WORKER'S COMP INFORMATION SHEET
TO BE COMPLETED BY EMPLOYER ON EACH WORKERS COMPENSATION CLAIM
INFORMATION REQUESTED BY PUBLIC EMPLOYEE CLAIMS DIVISION

8/2007

1) Employer San Jacinto Unified School District

2) Employee's Name Jones, Angela AASIS Employee ID No. _____

3) Injury Date 12 / 05 / 1959 Date Disability Began ____ / ____ / ____

4) Has employee returned to work? _____ If so, date ____ / ____ / ____

5) Who selected initial treating physician? ☐ Employee ☐ Employer

6) Did employee's salary continue while off work?
If so, check source and indicate time period

☐ Sick Form ____ ____ / ____ Through ____ / ____ / ____
☐ Annual From ____ / ____ / ____ Through ____ / ____ / ____
☐ Other From ____ / ____ / ____ Through ____ / ____ / ____

7) Employer claim recommendation: Accept ☐ - or - Deny ☐

If recommendation is to deny, explain and attach extra page if needed:

_____

_____

8) Other employees injured in this accident _____

9) Checklist: First report of injury or illness (Form IA-1)

Employer Name & Address (Upper Left Hand Corner) ☐
Wage Information ☐ Date of Hire ☐
Date Disability Began ☐ Return to Work Force ☐
Contact Name/Phone Number (Whom we should call if we have questions) ☐
Specific activity & work process employee was engaged in when accident occurred. ☐
Witness (or person having immediate knowledge) ☐
Date prepared/signature/phone number ☐
Attach notes & bills from medical providers if available ☐

10) Have employee complete AR-N and refer to notices on the reverse side of the form. ☐

Name: _____ Title: _____ Date: _____

Phone: _____ Fax: _____

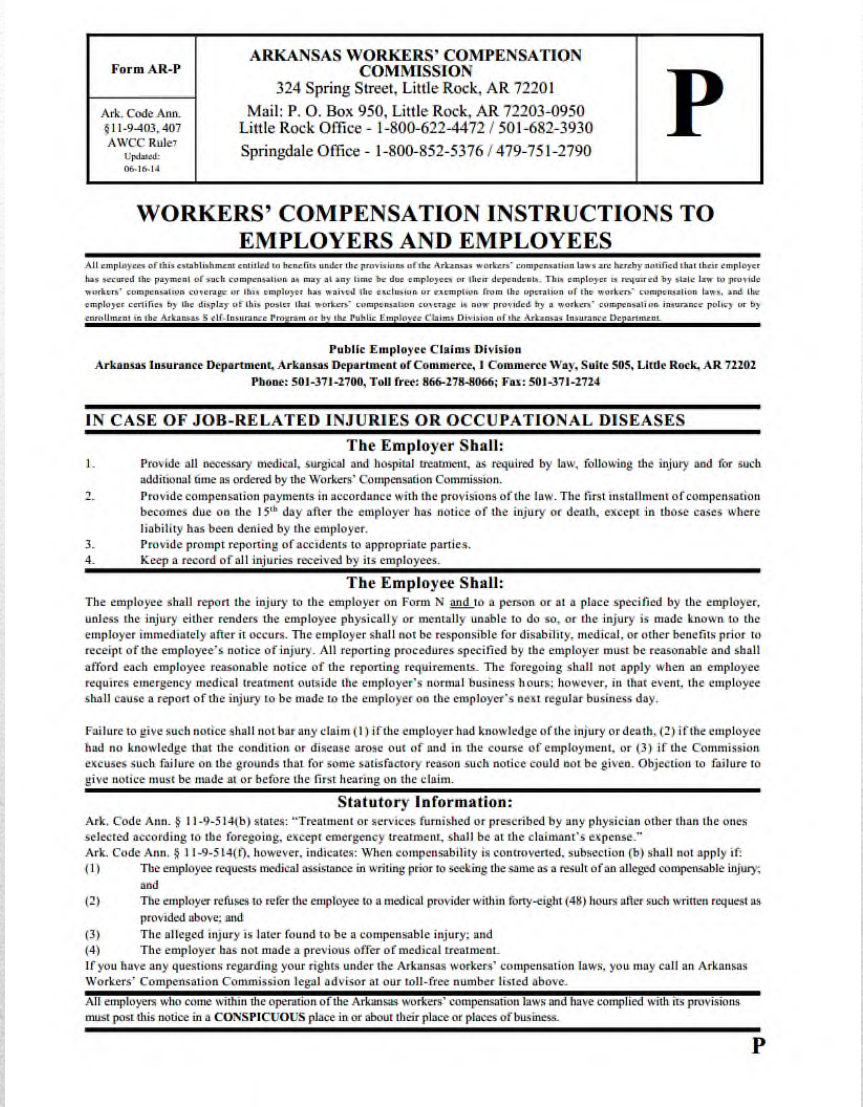
Forms to Be Posted

Form P – Workers' Compensation Notice

Form H – Managed Care Notice

Company Nurse Form

Forms to Be Posted – Form P



Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Springdale Office - 1-800-852-5376 / 479-751-2790	P
Ark. Code Ann. §11-9-403, 407 AWCC Rule7 Updated: 06-16-14		

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

Public Employee Claims Division
Arkansas Insurance Department, Arkansas Department of Commerce, 1 Commerce Way, Suite 505, Little Rock, AR 72202
Phone: 501-371-2700, Toll free: 866-278-8066; Fax: 501-371-2724

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. 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.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. § 11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."
Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

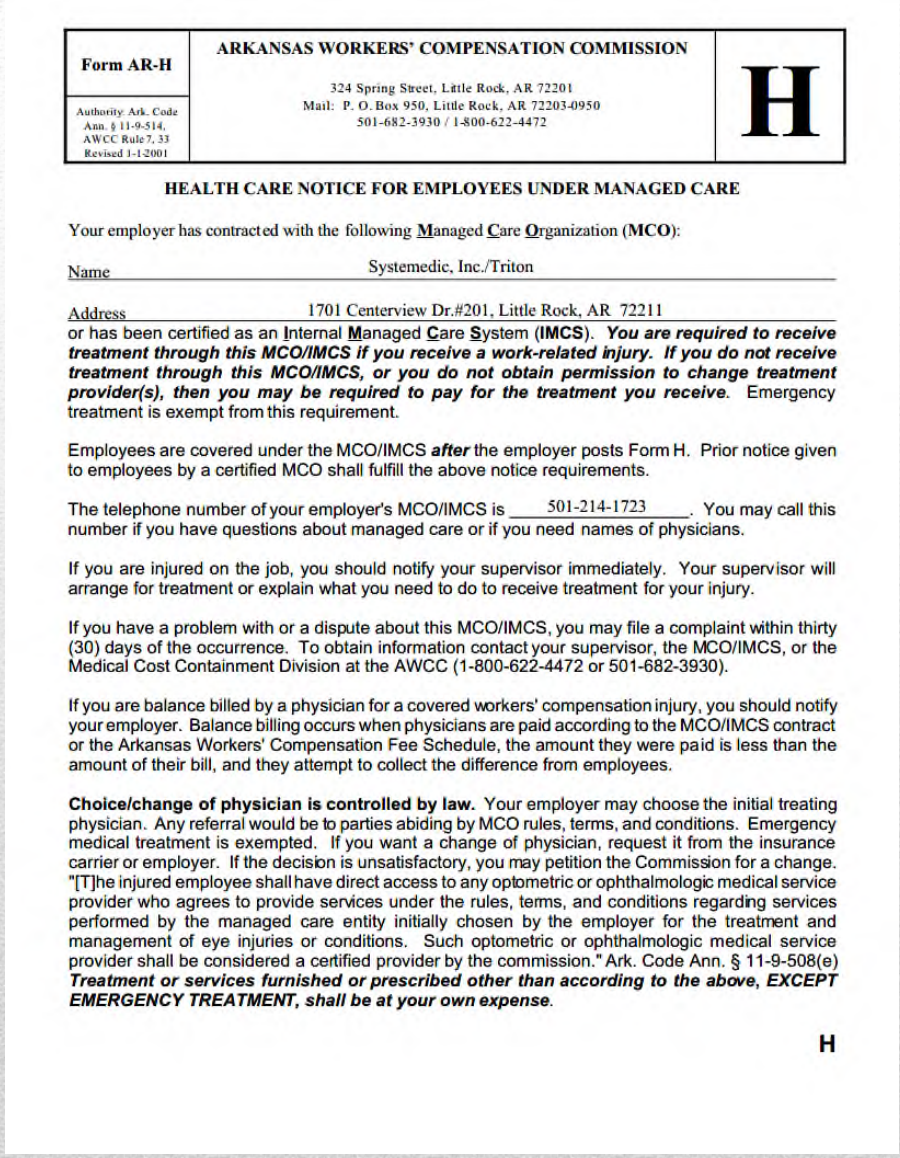
(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and
(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and
(3) The alleged injury is later found to be a compensable injury; and
(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

P

Forms to Be Posted - Form H



Form AR-H	ARKANSAS WORKERS' COMPENSATION COMMISSION	H
Authority: Ark. Code Ann. § 11-9-514, AWCC Rule 7, 33 Revised 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

HEALTH CARE NOTICE FOR EMPLOYEES UNDER MANAGED CARE

Your employer has contracted with the following **M**anaged **C**are **O**rganization (**MCO**):

Name Systemedic, Inc./Triton

Address 1701 Centerview Dr.#201, Little Rock, AR 72211

or has been certified as an **I**nternal **M**anaged **C**are **S**ystem (**IMCS**). ***You are required to receive treatment through this MCO/IMCS if you receive a work-related injury. If you do not receive treatment through this MCO/IMCS, or you do not obtain permission to change treatment provider(s), then you may be required to pay for the treatment you receive.*** Emergency treatment is exempt from this requirement.

Employees are covered under the MCO/IMCS ***after*** the employer posts Form H. Prior notice given to employees by a certified MCO shall fulfill the above notice requirements.

The telephone number of your employer's MCO/IMCS is 501-214-1723. You may call this number if you have questions about managed care or if you need names of physicians.

If you are injured on the job, you should notify your supervisor immediately. Your supervisor will arrange for treatment or explain what you need to do to receive treatment for your injury.

If you have a problem with or a dispute about this MCO/IMCS, you may file a complaint within thirty (30) days of the occurrence. To obtain information contact your supervisor, the MCO/IMCS, or the Medical Cost Containment Division at the AWCC (1-800-622-4472 or 501-682-3930).

If you are balance billed by a physician for a covered workers' compensation injury, you should notify your employer. Balance billing occurs when physicians are paid according to the MCO/IMCS contract or the Arkansas Workers' Compensation Fee Schedule, the amount they were paid is less than the amount of their bill, and they attempt to collect the difference from employees.

Choice/change of physician is controlled by law. Your employer may choose the initial treating physician. Any referral would be to parties abiding by MCO rules, terms, and conditions. Emergency medical treatment is exempted. If you want a change of physician, request it from the insurance carrier or employer. If the decision is unsatisfactory, you may petition the Commission for a change. "[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. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission." Ark. Code Ann. § 11-9-508(e) ***Treatment or services furnished or prescribed other than according to the above, EXCEPT EMERGENCY TREATMENT, shall be at your own expense.***

H

Forms to Be Posted –

Company Nurse Form

AVAILABLE
24 HOURS A DAY

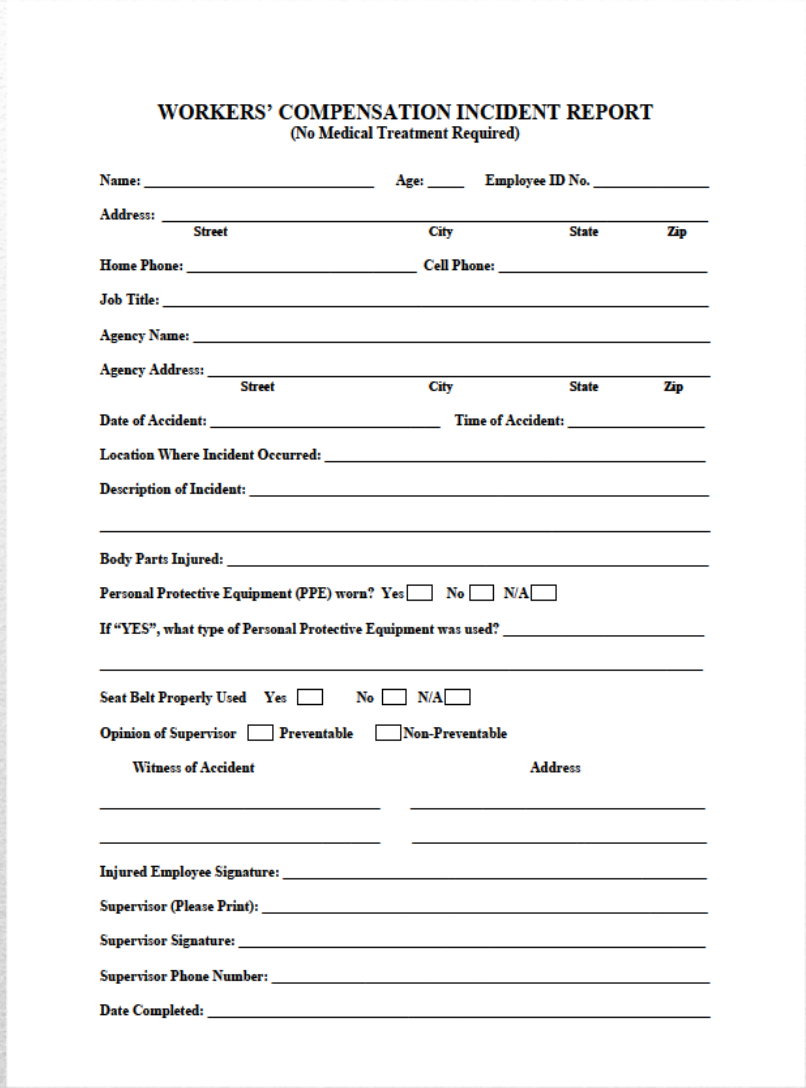
1-855-339-1893

Employer Name (Nombre De Compania)	Search Code (Código Del Búqueda)
AR Insurance Department	EU01

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.
2. **Supervisor/Injured worker immediately calls injury contact center.**
   Supervisor / Empleado lesionado llama de imediato al centro de contacto para lesiones.
3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Company Nurse obtiene información por teléfono y asiste al empleado lesionado en adquirir el tratamiento médico adecuado.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

Incident Report Form to use if an agency does not have one for incidents not requiring medical treatment



WORKERS' COMPENSATION INCIDENT REPORT
(No Medical Treatment Required)

Name: _____ Age: ____ Employee ID No. _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Job Title: _____

Agency Name: _____

Agency Address: _____
Street City State Zip

Date of Accident: _____ Time of Accident: _____

Location Where Incident Occurred: _____

Description of Incident: _____

_____

Body Parts Injured: _____

Personal Protective Equipment (PPE) worn? Yes ☐ No ☐ N/A ☐

If "YES", what type of Personal Protective Equipment was used? _____

_____

Seat Belt Properly Used Yes ☐ No ☐ N/A ☐

Opinion of Supervisor ☐ Preventable ☐ Non-Preventable

Witness of Accident Address

_____ _____

_____ _____

Injured Employee Signature: _____

Supervisor (Please Print): _____

Supervisor Signature: _____

Supervisor Phone Number: _____

Date Completed: _____

What is a Call Confirmation Number?

* A number **(eight-digit alphanumeric)** assigned to the Report of Injury to reference the call.

* In some cases a follow-up call MAY be necessary and this number references the original call.

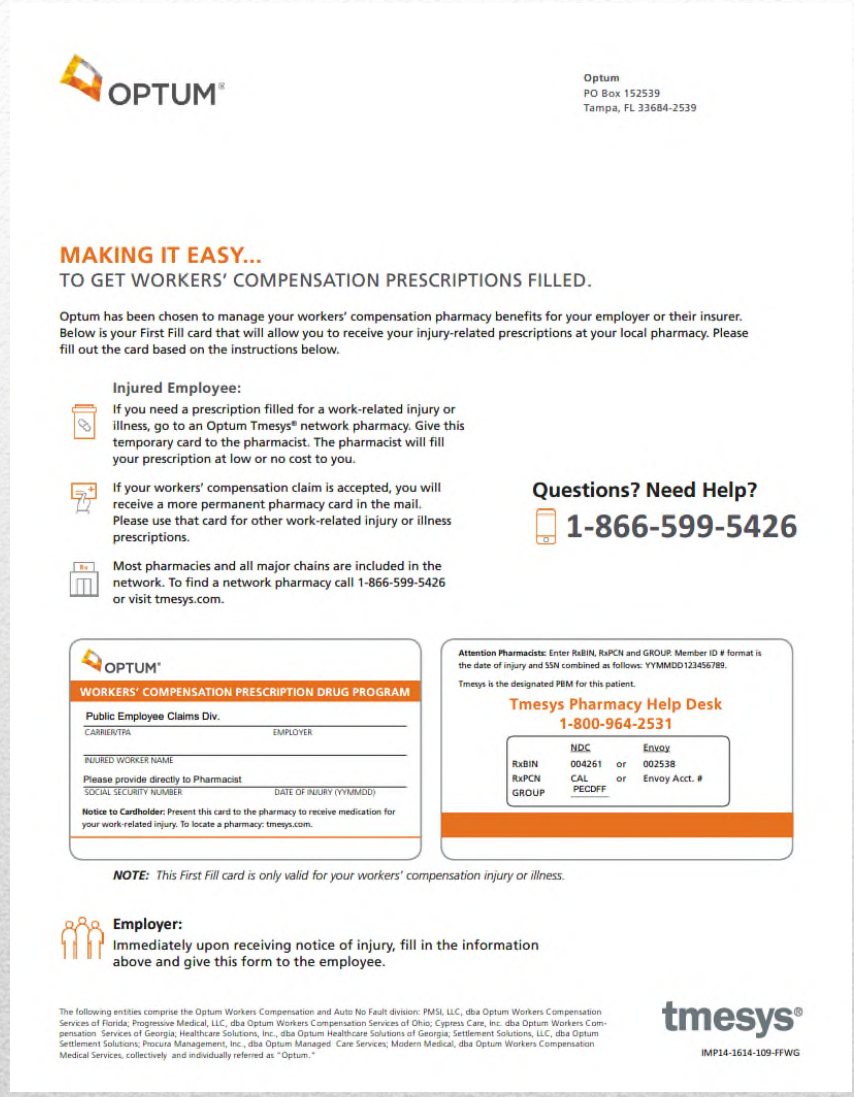
* The injured **employee should record and maintain** this number.

Temporary Prescription Form

*** Supervisor/Designated Person needs to complete the form and give to the injured employee at the time he/she reports the injury.**

The form needs to be given to the employee prior to receiving medical treatment, if possible.

Temporary Prescription Form



OPTUM

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?
1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Public Employee Claims Div.

CARRIER/TPA | EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER | DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PECDFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:
Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-109-FFWG

Frequently Asked Questions (FAQ)

Q. Should every workplace injury be reported to The Company Nurse Hotline?

A. No, only when medical treatment is needed.

Q. My date of injury was before the implementation date. Do I call the Company Nurse Hotline or complete forms?

A. If the injury has not been previously reported, call Company Nurse. If the injury has been reported, complete the remainder of the forms and fax to Public Employee Claims Division.

Q. Will The Company Nurse Hotline provide general health care advice?

A. No. This hotline is only for work-related injuries that need medical treatment.

Q. Is the call confirmation number the same as the claim number?

A. No

Q. Is The Company Nurse Hotline my Workers' Compensation Insurance?

A. No. Company Nurse provides the initial injury triage, offers care advice and initiates the injury reporting process. Public Employee Claims Division (PECD) is responsible for our claims processing and administration.

Q. What happens if the employee is on HOLD for an extended period of time waiting for a Nurse?

A. The protocol is to answer every call – there is no voicemail. Calls are initially answered by an Injury Care Coordinator (ICC). During unexpected high volume time periods, the ICC will take a contact phone number, and a Nurse will return a call as soon as possible, typically within a few minutes. Average length of call is 8 – 12 minutes.

Q. After the injured employee has been treated by a medical provider, does he/she need to call The Company Nurse Hotline back and update them with the treatment outcome and/or progress?

A. No. Any updates on the employee's condition, after treatment should be provided to their supervisor and Public Employee Claims Division.

Summary of Procedures

- **The injured employee should notify his/her supervisor immediately. In the case of an emergency, call 911 or transport the injured employee to the closest Emergency Room (ER) facility.**

- **The injured employee should call the Company Nurse Injury Hotline. If the injured employee cannot make the call, the supervisor should call.**

- **Company Nurse will gather all the appropriate information and make care recommendations.**

Summary of Procedures…

- **Company Nurse will email a Report of Injury to the appropriate contact person(s) designated by the agency, and the Public Employee Claims Division. The Report of Injury is for information only. There is nothing to be done with this report.**

- **Company Nurse will email the workers' compensation forms (pre-generated with the information called into Company Nurse) to the designated agency contact person and the Public Employee Claims Division.**

Summary of Procedures…

- **The contact person designated by the agency will need to print the forms. The supervisor and injured employee will need to review the following forms and make appropriate changes: AR-N, PECD Form 1, All the forms will need to be signed and faxed to Public Employee Claims Division at 501-371-2733.**

- **The supervisor or other employee designated by the agency will need to give the injured employee the Temporary Prescription Form prior to the employee receiving medical treatment (if possible).**

Public Employee Claims Division
1200 W. Third Street
Little Rock, AR 72201

501-371-2700 - Main Number

Fax Numbers

501-371-2733 New Claims Only
501-371-2724 Correspondence