



Public Employee Claims Division

Workers' Compensation

Initial Procedures



INJURY HOTLINE

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 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



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 occurred 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.

CONFIDENTIALITY NOTICE - This document may contain information that is confidential or legally privileged. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that you must not read, disclose, copy, distribute or use any of the information contained in this document. If you have received this document in error, please immediately notify Company Nurse at 888-817-9282 or service@companynurse.com and destroy this document in its entirety.

Thank you.



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	<input type="checkbox"/> Report Only NO TRIAGE
Cuts, Lacerations, Scrapes, Punctures	<input type="checkbox"/> 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	<input checked="" type="checkbox"/> Patient Understands
puncture wound of undetermined depth? - Yes	<input checked="" type="checkbox"/> Patient Compliant
Patient Override	
Patient Reason	
Care Advice	
3. See Physician 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	



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.
Triage to be seen. Agreed with the plan.

Sample Claim

pg. 1 of 5

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	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) Same As Carrier	
CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE				
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
ADDRESS (INCL ZIP) 1245 E Elm St Rail Road Flat, CA 75248		SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input checked="" type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	STATE OF HIRE AR
PHONE 949-231-6738		# OF DEPENDENTS	OCCUPATION/JOB TITLE Food Service Worker	
			EMPLOYMENT STATUS	
			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 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS 12/7/2012	TIME OF OCCURRENCE 7:30 () CANNOT BE DETERMINED	AM PM <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM
CONTACT NAME/PHONE NUMBER Russel Crow 949-623-5795		TYPE OF INJURY/ILLNESS Laceration		DATE EMPLOYER NOTIFIED 12/7/2012
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		PART OF BODY AFFECTED Right Thumb		DATE DISABILITY BEGAN 12/7/2012
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.				
DATE RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	
			YES NO 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

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(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. §11-9-201, 504, 514 AWCC Rule 949.33 Revised 1-1-2004 Updated 4-1-2006	ARKANSAS WORKERS' COMPENSATION COMMISSION		N
	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)

JONES	ANGELA		000-22-5555	949-231-6738
<small>Employee's Last Name</small>	<small>First Name</small>	<small>MI</small>	<small>Social Security Number</small>	<small>Home Phone No.</small>
1245 E. ELM ST	RAIL ROAD FLAT		CA	75248
<small>Street Address or P.O. Box</small>	<small>City</small>		<small>State</small>	<small>Zip Code</small>
<small>Child Support Obligation:</small> <input type="checkbox"/> Current <input type="checkbox"/> Past Due Payable to:				

EMPLOYER INFORMATION (Please Print)

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

ACCIDENT INFORMATION (Please Print)

KITCHEN	12/7/2012	7:30 AM	Date 12/7/2012 Time 7:30
<small>Place of Accident</small>	<small>Date of Accident</small>	<small>Time of Accident</small>	<small>Employer Notified of Accident</small>
<small>What part of your body was injured?</small> RIGHT THUMB			
<small>Briefly discuss the cause of injury.</small> 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. §11-9-106(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."

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.

Arkansas Insurance Department

Asa Hutchinson
Governor



Allen Kerr
Commissioner

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's Signature

Date

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

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Employee
signature
required

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: _____

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	P
Ark. Code Ann. §11-9-403, 407 AWCC Ruler Updated: 06-16-14	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	

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 employee is required by state law to provide workers' compensation coverage or the 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
1200 West Third Street
Little Rock, Arkansas 72201
Phone: (501) 371-2700 Toll Free (866) 278-8066

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 Managed Care Organization (MCO):

Name SYSTEMEDIC/USABLE

Address 10809 Executive Center Drive, Suite 105, Little Rock, AR 72211
or has been certified as an Internal Managed Care System (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) 227-5553. 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

IN CASE OF A WORKPLACE INJURY



1-8 - -

Available 24 hours / 7 days a week

1. Injured worker notifies Supervisor
2. If employee suffers a non-life threatening workers' compensation injury and needs medical treatment, Supervisor/Injured Worker immediately calls Company Nurse toll free number
3. Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment

Employer Name	Search Code

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.

Visit us online: www.CompanyNurse.com

NOT RELATED TO A WORK PLACE INJURY:



24/7 Nurse Line 1-8 - - Option 1

When should you call the 24/7 Employee Benefits Nurse Line?

1. For questions on a non-workers' compensation health condition or illness
2. When you need help deciding if you should see a doctor or go to the ER not involving workers' compensation
3. If you want more information on a medical test or procedure.
4. When you call, you will speak directly with a Registered Nurse who can help you with your health questions.

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.
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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



P.O. Box 152539
Tampa, FL 33684-2539

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

Helios 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 a Helios 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 866. . . or visit www.tmesys.com and click on "Pharmacy Locator."

Questions? Need Help?



tmesys	
Public Employee Claims Div.	
CARRIER/TA	AGENCY
INJURED WORKER NAME	
NUMBER	DATE OF INJURY (MM/YY)
<small>Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy, visit www.tmesys.com/pharmacylocator.</small>	
HELIOS	

<small>Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury, and combined as follows: YMMMD0023456789. Tmesys is the designated PBM for this patient.</small>	
Tmesys Pharmacy Help Desk 800. . .	
RxBIN	<u> </u> NDC or Emvy
RxPCN	or
GROUP	or
HELIOS	

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.



IMP14-1414-10-TMESYSARPECD



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.**
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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.**
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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.**

 - ❖ **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).**
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**Public Employee Claims Division
1200 W. Third Street
Little Rock, AR 72201**

501-371-2700 - Main Number

Fax Numbers

501-	-	New Claims Only
501-	-	Correspondence
