WRITTEN QUESTIONS AND ANSWERS

SP-16-0143 Worker's Compensation Claims Administration Software

ANSWERS ARE IN BLUE

1. Question: May companies from Outside USA submit a proposal?
   Answer: Yes, bids are welcome from countries outside of the United States.

2. Question: Will meetings with the agency need to take place on-site?
   Answer: Yes. During the RFP process, the oral presentations will be conducted on-site in Little Rock, Arkansas. After contract award, the successful bidder must attend some implementation meetings and training must be conducted onsite in Little Rock, Arkansas.

3. Question: May tasks (related to the RFP) be performed outside the USA?
   Answer: Some tasks can be performed outside of the USA. However, no computers located outside the US should access any claims data and no claims data, electronic or hard copy, should be transferred outside of the US for any data migration task or effort. It is preferred that the help desk be located within the continental United States. All communications between the vendor and the State of Arkansas regarding the software and implementation must be in English.

4. Question: May proposals be submitted via email?
   Answer: No, proposals may not be submitted electronically. Proposals must be sealed and submitted at the place and on or before the date and time set forth in the Request for Proposal.

5. Question: Is an incumbent vendor providing Worker's Compensation claims software or maintenance and operation services, or is the system currently maintained using in-house resources?
   Answer: AID's current system is maintained using in-house resources.

6. Question: When you site 100 concurrent users, are you referring that;
   A. You have 100 users which will be logged in and using the system at any one time.
      a. Answer: No. We anticipate no more than 30 users logged in and using the system at any one time.

   B. You have up to 100 users (or more), some casual/part-time, which will use the system from time to time which would not require 100 full-time licenses.
      a. Answer: Yes. We would anticipate having no more than 30 users logged in and using the system at any one time. The rest would be casual/part-time.

7. Question: Can you provide the current incident reporting forms used?
   Answer: Yes. See attached.
   The only form not attached is the Company Nurse Form. We would be looking at doing a very close to standard import of information from Company Nurse with maybe only a slight variation from what other claims administrators are importing from Company Nurse via electronic data exchange. We do not collect the Workcomp Injury incident Report Form unless the claimant ends up receiving medical treatment which becomes a claim. The Workcomp Injury Incident Report – No Medical Treatment form is retained by the agency and only submitted if a claim arises later out of the incident. Our plan is that we would not need to automate that form. We would just scan and retain it as an image.

8. Question: How many AID adjusters (total vs concurrent) will be using the claims system?
   Answer: We will have 10 adjusting staff. However, we have legal and support staff that will need to access the system as well, so we anticipate 25 to 30 concurrent full users. We may have some limited users (not more than 70) for limited view capability only from some agencies.

9. Question: How many total claims (closed and open) are currently housed in AID's legacy database?
   Answer: As of 3:38 P.M. on 7-22-2016, we have a total of 91,710 claims (both open and closed) in our legacy database. Roughly 50,000 of these will have only very basic claims data (claimant, name, address, gender, social security number, date of birth, telephone number, employer code, receive date, open date, close date, denied date, reopen date, and injury codes) and not have payment information or notes. As of 3:38 P.M. on 7/22/2016, 1,773 (one thousand seven hundred seventy three) of these 91,710 claims are currently open in our legacy database.

10. Question: Is the State willing to consider alternative approaches to Must/Shall have requirements where we think the State would be best served?
    Answer: Must/Shall are mandatory requirements.

11. If a vendor submits a bid for client hosted (State hosted) and Vendor hosted, would you like 2 separate bids, or one bid with 2 different pricing models?
    Answer: Separate proposals should be submitted. If you will be submitting multiple proposals they must be placed in separate packages and should be clearly marked as alternate proposals.

12. If a vendor submits a Vendor Hosted solution, is VM ware still required, or will direct browser access be allowed?
    Answer: If the application is hosted by the vendor (either in the cloud or on servers at the vendor), browser access for AID users is required.

13. The RFP states: "Include how information can be captured as well as disseminated from your solution." [Could you please provide examples to illustrate the meaning of the question?]
    Answer: How are data, documents, information Input/Imported/Captured into the system and Produced by the system (How are data and reports extracted/saved from the system). Are there any options for batch data input/export. Are there any web services to allow for data input/extraction/querying?.

14. The RFP states: "Describe and provide a visual representation of how your proposed system will provide the following:" [Do you want a visio-type diagram or will screen shots from the application suffice?]
    Answer: Visio or screen shots are both acceptable.

15. The RFP states: “Import of claims data from telephonic reporting company.” [Please describe how the State wants this to work—an interface to a 3rd party system or the ability for a 3rd party to enter data directly into the application?]
    Answer: It would be an interface with the telephonic reporting/nurse triage company.

16. Would you consider a 2 week extension to the Bid Opening Date?
    Answer: The Bid Opening Date may be extended for some amount of time. The vendor is responsible for checking the OSP website, http://www.arkansas.gov/dfa/procurement/bids/index.php, for any and all addenda posted up to bid opening.

17. What is the Anticipated Bid Award Date?
    Answer: AID anticipates the award will be in early October. Following the Bid Opening, AID will evaluate proposals and proceed with oral presentations/demonstrations. Once an anticipated successful vendor has been determined, the anticipated award will be posted on the OSP website for fourteen (14) days prior to the issuance of a contract.

18. What, if any expenses would the State see as applicable or anticipated in regards to Section 1.9(F)
    Answer: The vendor is responsible for all costs associated with the demonstration including vendor’s meals, travel and lodging.

19. Further discovery with the State during the Orals, Demonstration or further Discussion may uncover additional requirements that are not detailed in the RFP. Please confirm as these requirements are identified in greater detail the State would acknowledge these as a possible change of scope to the RFP and revised pricing may be applicable.
    Answer: Negotiations may take place prior to finalization of the contract if there are changes to the scope. Any amendments to costs in the contract after it is finalized would require legislative committee approval. Any cost not identified by the successful vendor, but subsequently incurred in order to achieve successful operation will be borne by the vendor.

20. Can the vendor include additional information or attachment with the price sheet to more clearly define the pricing breakout that is included in the RFP response?
    Answer: Do not submit any ancillary information not related to actual pricing in the sealed pricing package.

21. Please provide a breakout of the total number of users who will need to be licensed:
    a. System Administrators - Answer: 2
    b. Full System Access Users - Answer: minimum 26, 30 at most

c. Limited System (Role) based Users - Answer: up to 70 at most

22. For further clarification to Section 2.3, D (9) please provide a use case scenario for the complete desired process and result.
Answer: We would like to have a button in the claims software to run a query in Xerox Docu-Share to list images in the Docu-Share database regarding a claim while we have the claim information open in the claims software. We would like to have buttons in the Claims Software which would issue a call to Docu-Share to list all images regarding the claim, to list just bills and to list legal category images in the Xerox Docu-Share database.

23. Please confirm that Xerox Docu-share is the imaging software database for interfacing
Answer: Xerox Docu-Share is the imaging software database for interfacing.

24. Please list all desired data conversions and Interfaces desired as part of this project
    i. External (e.g. TPA, Medical Bill Review, Pharmacy,) and
    ii. Internal (e.g. HR, AP, Accounting, Payroll have been mentioned)

- Are they in-bound, outbound or bidirectional?
- What is frequency (Daily, Weekly, Monthly, Quarterly)?
- Which (if any) data sources will be ongoing only a one-time conversion?
- What is frequency (Daily, Weekly, Monthly, Quarterly)?

Answer: Conversion of our claims data and notes from our current SQL claims database. Conversion of payment history data from our current SQL database.

i. External:
    a. Import of claims information from Company Nurse Export of claims information to pharmacy benefit manager and Systemedic (medical bill review)
    b. Import of EOB information and image of EOB and bill from Systemedic (medical bill review).
    c. Import of bills from pharmacy benefit manager, Systemedic and Company Nurse
    d. Export of payment of bills to SAP system using ASCII flat text file.
    e. Optional: Export and import of data from ISO Claimsearch at least once a day.

- Are they in-bound, outbound or bidirectional?
Answer: Bidirectional for accounts payable to SAP system with export of payment information and importation of Check #'s and issuance date. Payment files would typically be once a day. However, the monthly and bimonthly bills are typically processed separately from normal medical and indemnity payments and are sent in a separate file resulting in multiple payment files a few days a month.

- What is frequency (Daily, Weekly, Monthly, Quarterly)?
Answer: Importation of claims information from Company Nurse would be more than once a day. We are open to discussions as to how many times a day this action would be performed. Claims data export to pharmacy benefit manager is twice daily. Claims data export to Systemedic (MCO) is once a day. Bill from PBM is once every two weeks for retail and once every two weeks for out-of-network bills. Bill from Company Nurse is once a month. Bill from Systemedic (MCO) is once a month.Bill from UAMS College of Pharmacy is once a month.

- Which (if any) data sources will be ongoing only a one-time conversion?
Answer: Claims data and notes and payment data from current SQL Databases. We believe this would involve a one-time conversion of data before go-live. This would probably be done in two separate batches: One for the vast majority of historical data and then a supplemental for any data between the initial conversion and go-live.

25. Where is the organizational hierarchy coming from, will it be loaded from a SAP, spreadsheet or manually entered?
Answer: Spreadsheet

26. How many layers deep is your org hierarchy?

Answer: We track employers by 3 levels: 1st level: State, County, City, Schools; 2nd level Name of Agency, School District, County or City; 3rd level for State Agencies only which are by location or district. Smaller state agencies, boards and Commissions only have two letters to designate them since they may only have one location. The way we currently track employer are by a 2 or 4 character code: First two characters are alphabetical; 2nd 2 characters are location or division/district. All residual city claims start with CI; All county claims start with a CO, all school claims start with SH. State agencies start with other two letters. Example: Highway Department District 1 is “BG01”.

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: _____ Tel #_____

Address: _____

Birth Date: _____ Marital Status: _____ 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: _____

Job Title: _____ Length of Employment: _____

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

_____

Date of Accident: _____ Time: _____ Place: _____

Describe activity of employment engaged in at time of injury: _____

_____

Describe how injury occurred: _____

_____

_____

To whom did you report the injury: _____

When: _____ Supervisor's Name: _____

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

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: _____

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 _____

2) Employee's Name _____ AASIS Employee ID No. _____

3) Injury Date ____ / ____ / ____ 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: _____

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)

			Date /Time
Place of Accident	Date of Accident	Time of Accident	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."

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§ 11-9-701, 508, 514 AWCC Rule 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	

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

N

Employees Signature **Date**

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: _____

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 #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Public Employee Claims Division Arkansas Insurance Department 1200 West Third Street, Suite 201 Little Rock, AR 72201 (501) 371-2700	TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	

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

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)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.