Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Report Online

To use the app, you will first need to register on the Great American Insured Portal

https://insuredportal.gaig.com

1. **Click the Request Access link**
2. **Complete the Policyholder Registration form**
3. **Confirm the Insured Portal system generated "Identity Verification" email**

Preregistration Required

Call our reporting center

877-836-1555

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

Establishing a Managed Care Panel

Great American Insurance Group has contracted with Procura/Optum to provide customizable Physician and Clinic Networks for our insureds. These networks provide injured workers with industry leading care and medical treatment at significant cost savings to employers.

Most states have specific guidelines governing the right for an employer or employee to direct care in the event of an industrial injury. Some states require the establishment of a Medical Panel for the initial treatment of work-related injuries. Due to the significant cost savings associated with Medical Panels, Great American – Alternative Markets recommends that employers establish medical Panels for all work locations.

Mandatory Panel States: GA, PA, TN, VA

Medical Provider Network (Opt-in): California

Medical Panels will need to be established BEFORE you have your first claim. Please fill out the below questionnaire listing all work locations and send to:

AlternativeMarketsAccountServices@GAIG.COM

Once received, you will be contacted by a member of our account services team to discuss the needs of your business and how to best construct the medical panel that will deliver appropriate coverage to your employee population.

Questionnaire

Named Insured: _____

Location: _____

Address: _____

Contact name: _____

Contact phone number: _____

Employee count: _____

Current network: ☐ Yes ☐ No

GREAT AMERICAN. INSURANCE GROUP
Alternative Markets

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 TO

CHECK IF APPROPRIATE ☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

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

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX: M MALE; F FEMALE; U UNKNOWN

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

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

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

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

CAUSE OF INJURY CODE

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

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0	NO MEDICAL TREATMENT
1	MINOR: BY EMPLOYER
2	MINOR CLINIC/HOSP
3	EMERGENCY CARE
4	HOSPITALIZED > 24 HOURS
5	FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

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

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.

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

EMPLOYEE/WAGE

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

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

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
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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				
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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

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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.

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(Revised 1-1-2001)

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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.

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

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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.

Form AR-M	ARKANSAS WORKERS' COMPENSATION COMMISSION	M
Authority: Ark. Code Ann. ° 11-9-528, 529 AWCC Rule 8 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	

MONTHLY REPORT ON MEDICAL - ONLY INJURY DATA

TO BE COMPLETED BY CARRIERS AND SELF-INSURED EMPLOYERS EACH MONTH ON CASES NOT OPENED BY FORM 1 OR FORM C.

Report Period (Month, Year)	Carrier or Self-Insured Name		FEIN No.	
Claim Office/TPA Filing Report	Mailing Address	City	State	Zip Code

MONTHLY MEDICAL-ONLY INJURY DATA

Total No. of Medical-Only Injury Reports Received	Total No. of Days Lost	Total Medical Expense

Give Total Number of Reported Injuries by Body Part (Must Equal Total No. of Injuries Reported Above)

Head, Face and Neck: _____ Eyes, Ears, Nose and Mouth: _____ Hands, Arms and Fingers: _____
Back and Hip: _____ Chest and Lungs: _____ Legs, Feet and Toes: _____
Abdomen: _____ Other or Multiple: _____

CERTIFICATION

I certify that the foregoing is a complete and accurate report for the above referenced carrier or self-insured employer of all medical-only claims reported and paid by that entity for the report period.

Signature	Printed or Typewritten Name	
Title	Date	Telephone Number (including Area Code)

(See Instructions on Back of This Sheet)

AWCC Form M

(Monthly Report on Medical-Only Injury Data)

Instructions for **Form M**:

1. Send **Form M** to the AWCC Research & Statistics Section after the close of each month and by the 15th day of the next month.

2. Spell out the name of the carrier or self-insured; do not abbreviate.

3. Count calendar days lost rather than just work days.

4. All accidents/injuries resulting in disability of more than seven days, death cases, or those involving payment of weekly compensation shall be reported to the Commission on Form 1. In the event cases reported as medical-only develop into compensable cases, these previously-counted totals should be subtracted in subsequent Form M Monthly Reports.

5. All accidents/injuries, other than death, resulting in disability of seven days or less, must be reported on this form. This report is to be completed by all insurance carriers and self-insured employers providing workers~ compensation coverage in Arkansas. Companies/employers that have coverage with an insurance carrier are not required to complete this form.

6. Report expenses each month. When medicals are carried over into another month, expenses should be included on future **M Forms**, but the accident should only be counted once.

7. Separate reports must be submitted for each separate carrier or self-insured FEIN number.

8. Third-party administrators/service companies should NOT complete this form unless designated to do so by the carrier or self-insured. Reports with T No Activity š during the period must be completed and so indicated.

9. **NOTE**: The Commission has the authority to levy a fine up to $500 per report per carrier or self-insured FEIN for failure to submit or late submittal of this form. FAX reports are acceptable. The fax number is (501)682-2777.

Help with the Form M is available from the Research and Statistics Section. General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. ° 11-9-106(a): TAny 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.š

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.

(Place label indicating Insurer's Name,
Claims Office Address, Claims Office Phone Number
and Policy Expiration Date)

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.

AWCC Form P
(Posting Notice)

A posting notice is mentioned in **Ark. Code Ann. §11-9-403**, **Ark. Code Ann. §11-9-407** and **AWCC Rule 7**. **AWCC Form P** satisfies all requirements.

Form P:

1. Is to be on display in a conspicuous place;
2. Tells employers what to do when an employee is injured;
3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;
4. Lists the claims office that will be handling the insurance aspects of the case;
5. Gives the claims office telephone number;
6. Announces the expiration date of the insurance policy; and
7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P**. Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about Form P is available from 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."

Formulario AR-P	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS 324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Springdale: 1-800-852-5376 / 479-751-2790	**P**
Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 06-16-2014 En Español: 10-15-2004		

INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todos los empleados de este centro que tengan derecho a beneficiales en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus empleados cobertura por compensaciones o ha renunciado a la exención o exclusión de la ejecución de la legislación en materia de compensaciones a los trabajadores y certifica mediante la muestra de este cartel que en la actualidad ofrece cobertura a sus trabajadores dentro de una póliza de seguro de compensación de los trabajadores o por su participación en el Programa de Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

(Pegar la etiqueta con el nombre de la aseguradora,
la dirección de la oficina de reclamaciones, el número de teléfono de la oficina
de reclamaciones y la fecha en que expira la póliza).

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 días desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El artículo 11-9-514(b) del Ark. Code Ann. establece que: "El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante."
El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:
(1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
(2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
(3) Posteriormente se descubre que la supuesta lesión es compensable; y
(4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREEMINENTE** en su centro de trabajo o las cercanías.

Formulario P de la AWCC
(Notificación)

En los **apartados 11-9-403 y 11-9-407 del Ark. Code Ann. y la Regla 7 de la AWCC** se menciona una notificación. El **formulario P de la AWWC** cumple todos esos requisitos.

Formulario P:

1. Debe mostrarse en un lugar preeminente;
2. Dice a los empleados qué deben hacer cuando un trabajador se lesiona;
3. Instruye a los empleados para que notifiquen las lesiones inmediatamente al empleador (o no más tarde del final del siguiente día laborable);
4. Enumera la oficina de reclamaciones en la que se tratarán los aspectos vinculados a seguros del caso;
5. Anuncia la fecha en que expira la póliza de seguros;
6. Ofrece números de teléfono del asesor legal de la Comisión de Compensaciones de los Trabajadores de Arkansas por si alguien necesita ayuda.

Los empleadores que no cuenten con un **formulario P** podrán perder el derecho a utilizar el **formulario N** como defensa en un litigio. Los empleados que desobedezcan las instrucciones del **formulario P** podrán sufrir retrasos en el beneficio de cualquier prestación en los casos que se impugnen o corren el riesgo de perderlos.

La AWCC ofrece copias de muestra pero no suministra el **formulario P**. Las aseguradoras deben enviar a sus asegurados un número adecuado de copias y los auto-asegurados deben contratar el suministro con una imprenta. Las aseguradoras y los empleadores pueden ampliar el **formulario P** para publicarlo.

Puede obtenerse información sobre el formulario P de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de beneficiales o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores."

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

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	

EMPLOYER INFORMATION (Please Print)

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

ACCIDENT INFORMATION (Please Print)

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

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

WITNESSES

Name and address of witness(es), if any: _____

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.š

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

EMPLOYEE˜S NOTICE OF INJURY

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately.

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.

T(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.š

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 Tregular treating physicianš 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

Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Ann., apartado 11-9-702, 508, 514 AWCC Norma 33 Revisado: 1-1-2001 En Español: 10-15-2004 Actualizada: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

DATOS DEL EMPLEADO (utilizar tinta y mayúsculas)

Apellido	Nombre	Inicial del 2nd nombre	# de la Seguridad Soc.	Fecha de nacimiento	(Prefijo), número de teléfono particular
Dirección o apartado de correos		Ciudad	Estado	Código postal	
¿Tiene obligacion de pagar manutencion de sus hijos? ☐ Estoy al corriente ☐ Estoy atrasado/a ☐ Pagaderos a:					

DATOS DEL EMPLEADOR (utilizar mayúsculas)

Nombre del empleador (denominación con la que opera)			(Prefijo), número de teléfono del empleador
Dirección del empleador	Ciudad del empleador	Estado	Código postal

INFORMACIÓN SOBRE EL ACCIDENTE (utilizar mayúsculas)

Lugar del accidente	Fecha del accidente	Hora del accidente	Día /Hora Empleador informado del accidente

¿Qué parte del cuerpo se ha lesionado? _____

Describa brevemente las causas del accidente: _____

TESTIGOS

Nombre y dirección de los testigos, si procede: _____

Por la presente autorizo a cualquier hospital, médico, psicoterapeuta o profesional sanitario a suministrar al portador cualquier dato, oral o escrito, incluidos, entre otros, copias de los registros médicos relativos a mi estado físico, mental o emocional pasado, presente o futuro. Por la presente renuncio a mi privilegio médico (y psicoterapeuta o profesional sanitario)-paciente. Una copia fotostática de la presente autorización será tan válida como y efectiva como el original. Mi firma a continuación también indica que se me ha ofrecido el ejercicio de mis derechos relativos al cambio de médico. (Véase la información adicional al dorso.)

Fecha: _____ Firma: _____

Puede obtenerse ayuda con respecto al formulario N de la AWCC de la División del Asesor Legal (1-800-520-2511 o 501-682-3930). Puede obtenerse información de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de prestaciones o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores."

Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Ann., apartado 11-9-702 Revisado: 1-1-2001 En Español: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

NOTIFICACIÓN AL EMPLEADO - Cumplimente este formulario para entregarlo a su empleador inmediatamente.

Ark. Code Ann., apartado 11-9-701. Notificación de fallecimiento o lesión.

(a) (1) A menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo, o si se comunica al empleador inmediatamente después de producirse, el empleado deberá informar del accidente a su empleador en una forma establecida o aprobada por la Comisión de Compensación de los trabajadores y a una persona y en un lugar especificado por el empleador, y el empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente.

(2) Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación.

(3) Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

(b) (1) La falta de notificación no anulará las reclamaciones si:

(A) El empleador tiene conocimiento del fallecimiento o lesión; o

(B) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o

(C) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.

(2) Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

ELECCIÓN/CAMBIO DE MÉDICO

Derechos y responsabilidades. El tratamiento o los servicios suministrados o prescritos por un médico distinto del seleccionado de acuerdo con las siguientes disposiciones, excepto el tratamiento de urgencia, correrán a cargo del solicitante/empleado.

Ark. Code Ann., apartado 11-9-508. Servicios y suministros médicos.

"(e) ...[E]l empleado lesionado podrá tener acceso directo a cualquier proveedor de servicios oftalmológicos u optométricos que acepte suministrar servicios de acuerdo con las normas y condiciones relativas a los servicios prestados por la entidad de atención gestionada inicialmente elegida por el empleador para el tratamiento y control de lesiones o afecciones de los ojos."

1. Su empleador podrá seleccionar al médico de atención primaria inicial de entre los asociados con MCOs certificadas.

2. Podrá solicitar un cambio de médico. Inicialmente debería solicitar un cambio a la aseguradora o el empleador. En el plazo de cinco días laborables desde su solicitud inicial de cambio de médico, la aseguradora o el empleador deberían notificarle su decisión de concederle o denegarle el cambio de médico.

3. Si su solicitud de cambio de médico es denegada podrá enviar una petición al Secretario de la Comisión de Compensación de los trabajadores para un (1) único cambio de médico.

4. **Si su empleador tiene un contrato con una MCO certificada**, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a la MCO certificada elegida por su empleador o que sea el médico que le atiende regularmente (Por "médico que le atiende regularmente" se entiende el facultativo que mantiene sus registros médicos y con el que cuente con un historial de tratamiento habitual anterior a la lesión para la que se puede solicitar la compensación"). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a la MCO certificada elegida por el empleador para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por la MCO certificada inicialmente elegida por su empleador.

5. **Si su empleador no tiene un contrato con una MCO certificada**, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a una MCO certificada o que sea el médico que le atiende regularmente (véase la definición anterior). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a una MCO certificada para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por cualquier MCO certificada.

Dorso/ formulario a dos caras

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 _____

Address _____

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 _____. 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.***

AWCC Form H

(Health Notice for Managed Care)

AWCC **Rule 33** (**Managed Care**) requires employers under a Managed Care program to have posted in the workplace a notice of the Managed Care Organization (MCO) or Internal Managed Care System (IMCS).

Form H, effective 1-1-2001, satisfies the requirements of revised Rule 33, effective 11-15-1999.

Help with Form H is available from the Medical Cost Containment Division. General information is available from 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.š

Form AR-W	ARKANSAS WORKERS' COMPENSATION COMMISSION	W
Authority: Ark. Code Ann. §11-9-518 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	

WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE

Weeks	Straight Time Worked		Wages Paid For Straight Time	Overtime Hours Worked		Wages Paid for Overtime
	Days	Hours		Days	Hours	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
51						
52						
Total						

AWCC No.

Carrier Claim No.

Employee Name:

Employee S.S.No.:

Employer Name:

Employer FEIN No.:

Carrier or Self-Insured Name:

Carrier NAIC No.:

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT

(To be completed only if claimant receives less than maximum benefits)

In completing the Wage Statement, in week one give information for the week prior to the injury and follow with preceding weeks. Days and hours of straight time work should be given in all cases.

Explanation of time lost by employee: _____

AWCC Form W
(Wage Statement)

1. The **AWCC Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number for the case, obtained from **AWCC Form A-110)** if the claimant receives less than the maximum compensation rate.

2. The average weekly wage of the injured worker shall "[I]n no case...be computed on less than a full-time workweek in the employment." **[Ark . Code Ann. ° 11-9-518(a)(1)]**

Information on Form W is available from the Office Services Section. General Information is available from the Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. °11-9-106(a): TAny 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.š

Form AR-S	ARKANSAS WORKERS˜ COMPENSATION COMMISSION	S
Authority: Ark. Code Ann. ° 11-9-529 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	

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	FEIN No.	City	State	Zip Code
Carrier Or Self-Insured Name	NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

3. Has employee returned to work? ❑ Yes ❑ No If yes, give date _____

4. If employee has returned to work, is he/she earning the same wages as before the injury? ❑ Yes ❑ No

   If not, please explain:

5. Has employee died? ❑ Yes ❑ No If yes, give date of death: _____

ADDITIONAL INFORMATION

CERTIFICATION

I certify that the information above is accurate according to the employer˜s/carrier˜s records.

Signature	Printed or Typewritten Name	Title	Date

AWCC Form S

(Supplemental Report)

This form reports any change-in-status, including, but not limited to:

1. The injured employee is back at work and drawing wages;
2. The injured employee is losing time again;
3. The injured employee has died;

Employers need to file **Form S** promptly.

Carriers file the form to fill in any "gaps" in time on **AWCC Form 4** when the case is being closed.

Contact the AWCC Office Services Section for help with the Form S. General information is available from 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.š

Form AR-S	ARKANSAS WORKERS˜ COMPENSATION COMMISSION	S
Authority: Ark. Code Ann. ° 11-9-529 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	

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	FEIN No.	City	State	Zip Code
Carrier Or Self-Insured Name	NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

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4. If employee has returned to work, is he/she earning the same wages as before the injury? ❑ Yes ❑ No

   If not, please explain:

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