

# Worker's Compensation Claims Reporting Procedures

## Worker's Compensation Claim Reporting Procedures

Your company's Worker's Compensation Insurance is provided by the Alabama Self-Insured Worker's Compensation Fund. Claims service is provided by Employer's Claim Management, Inc. If you have questions concerning Worker's Compensation, please call Employer's Claim Management for assistance.

Any work related injury can have the potential to become a Worker's Compensation claim. For this reason all employees should be instructed to report all work related injuries, no matter how minor, to their immediate supervisor as soon as possible. The supervisor is responsible for informing the proper management person as soon as possible. This person is then responsible for reporting the injury to Employer's Claim Management, Inc, using the Employer's First Report of Injury Form.

If an injury requires outside medical treatment:

- (1) Treatment must be provided by the **Company Authorized Physician or Clinic**.
- (2) All **referrals** to specialists **must be authorized** by Employer's Claim Management, Inc. 1-800-392-1551.
- (3) If an **emergency** situation occurs, get the injured person to the nearest medical facility.
- (4) Be sure **Post Injury Drug Testing** procedures are followed for all employees.

Complete a **First Report of Injury form** for all work related injuries that may have the potential to become a worker's compensation claim. Example: An employee states they strained a shoulder, but they don't want to go to the physician. In this situation, complete the First Report of Injury form and mark the top of the form "**For Record Only.**" Then send the form to Employer's Claim Management, Inc. When received, the claim will be filed as closed. If later the injured employee needs to go to the physician, contact Employer's Claim Management so the claim can be opened and properly investigated.

If your company makes the decision to pay a Medical Only claim out of company funds, send the First Report of Injury form to Employer's Claim Management marked as "For Record Only." If bills exceed what the company has decided to pay, inform the Claims Department of Employer's Claim Management and the claim will be opened and appropriately processed.

Be sure that company **Drug and/or Alcohol Testing Procedures** are enforced as specified by the company's written policy. It is critical that screens for substance abuse be administered when the employee seeks **initial medical treatment**. Employees must also be informed in advance, in writing that the refusal to cooperate with a test and/or a positive test result may have an impact on the availability of worker's compensation benefits.

Questionable claims should be reported to Employer's Claim Management as soon as possible by way of telephone, FAX, etc. Any Claim that involves severe injuries such as amputations, head trauma, death, etc., should be reported to Employer's Claim Management, Inc. immediately 1-800-392-1551.

Claims are filed by Social Security Number and employee name. When calling about a claim, provide the receptionist the Social Security Number and name of the injured employee and she will connect you to the examiner handling the claim.

### **If you need assistance with your worker's compensation program, contact:**

**Employer's Claim Management, Inc.  
P. O. Box 5614 (36103-5614)  
6316 Woodmere Blvd.  
Montgomery, Alabama 36117**

**Phone: 1-334-277-9395  
1-800-392-1551  
Fax: 1-334-277-5134**

# Claims Reporting

## Purpose:

Prompt claims reporting is essential and beneficial to all parties involved (employee, employer and insurance carrier). State requirements established by the Department of Industrial Relations also mandate the prompt reporting of employee injuries. The employer's First Report of Injury form is used to satisfy this requirement. (See back page).

## Procedure:

1. Work related injuries will be reported to Employer's Claim Management using the Employer's First Report of Injury form.  
  
Employer's Claim Management, Inc.  
P. O. Box 5614  
Montgomery, Alabama 36103-5614
2. The First Report of Injury Form should be completed and mailed to Employer's Claim Management within **48 hours** of being made aware of the injury.
3. For accidents involving death or severe injury such as an amputation or head trauma, a telephone or fax report should be made as soon as possible, followed by the mailed First Report of Injury form.

# Company Authorized Physician

## Purpose:

A worker's compensation claim and its related cost can be best controlled through a good employer/physician relationship. Alabama law allows the employer to direct the medical treatment of injured employees. The employer's right to direct medical treatment is critical to the claims management process and should be aggressively utilized at all times. For this reason the following policy regarding company authorized physicians has been established.

## Procedure:

1. If an employee injury is incurred and medical treatment by a physician is necessary, a Company Authorized Physician will be utilized. Instruction for seeking initial medical treatment should be provided by management or other designated persons.
2. At the present time, the company Authorized Physician is as follows:  
  
Name:  
Address:  
Phone #:
3. In the event an injured employee's initial treatment is performed by a hospital, emergency room, clinic or physician not authorized by the company, the employee may be asked to be evaluated by the Company Authorized Physician. This situation might occur if an employee is injured after regular working hours and/or at a job site where the Company Designated Physician is not readily assessable. If additional medical treatment is necessary, the Company Authorized Physician should be consulted.
4. All referral physicians should be cleared through the Claims Department of Employer's Claim Management, Inc. (334) 277-9395.

## Post Injury Drug Testing

### **Purpose:**

An injured employee who is intoxicated from the use of alcohol or impaired by illegal drugs may be denied worker's compensation benefits if a casual relationship between the injury and the impairment and/or intoxication can be established. Worker's compensation benefits can also be denied if the injured employee refuses to submit to or cooperate with a blood or urine test after the accident, after being warned in writing. For this reason, the following post injury policies and procedures have been established.

### **Procedure:**

1. Prior to the start of any work activities, all new employees will receive training regarding the company Drug and Alcohol Testing Policy. This will include a review of the established Company Drug and Alcohol Testing Policy and the signing of required acknowledgements.
2. Employees will be subject to post injury drug testing as specified by the Company Drug and Alcohol Policy, i.e. After a work related injury requiring off premises medical treatment.

## Modified Duty/Return to Work

### **Purpose:**

Availability of modified duty will assist employees in returning to their regular work routine and limiting time off from work. This, in turn, will allow the employee the opportunity of maintaining productive work habits while recovering from their injury.

### **Procedure:**

Prior to an employee injury:

1. The Company Designated Physician should be made aware that the company has a Modified Duty/Return to Work Program.

After an employee injury has been incurred:

1. Every effort will be made to provide modified duty to any and all injured employees who need modified duty to return to work.
2. Management should remind both the treating physician and insurance claim adjuster that modified duty will be made available.
3. If the injured employee has difficulty in completing Modified Duty assignments, the claims adjuster handling the claim should be notified as soon as possible and the injured employee referred back to the treating physician.

# EMPLOYER'S FIRST REPORT OF INJURY

- Number used by the employer to identify claim / injured employee
- ECMI Claim Number (leave blank)
- Employer's mailing address (where mail is received)

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2  
Rev. 4/2006

STATE OF ALABAMA  
**EMPLOYER'S FIRST REPORT OF INJURY  
OR OCCUPATIONAL DISEASE**  
Ombudsman 1-800-528-5166

Check here  
for Record Only

CLAIM REFERENCE				
1. Insured Report Number 23	2. Filing Office Claim Number	3. OSHA Log Case Number 26		
EMPLOYER				
4. Employer Business Name <b>ABC Inc.</b>		ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1 <b>123 Main Street</b>	10. Mailing Address 1 <b>P.O. Box 987</b>			
6. Physical Address 2	11. Mailing Address 2			
7. City <b>Ourtown</b> 8. State <b>Alabama</b> 9. Zip <b>12345</b>	12. City <b>Ourtown</b> 13. State <b>Alabama</b> 14. Zip <b>12345</b>			
15. Federal ID Number <b>987654321</b>	16. U.C. Account Number <b>00123567800</b>	17. NAICS <b>56471</b>		
INSURER / FILING OFFICE				
18. Insurer Name <b>ALABAMA SELF-INSURED WC FUND</b>		21. Filing Office Name <b>Employer's Claim Management, Inc.</b>		
19. Insurer Federal ID Number <b>63-0773197</b>		22. Mailing Address 1 <b>P.O. Box 5614</b>		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input checked="" type="checkbox"/>		23. Mailing Address 2 or Telephone Number <b>(334)277-9395</b>		
		24. City <b>Montgomery</b> 25. State <b>AL</b> 26. Zip <b>36103-5614</b>		
		27. Filing Office Federal ID Number <b>63-1034984</b>		
EMPLOYEE / WAGES				
28. First Name <b>John</b>		32. Employee ID Number <b>234-91-7865</b>		
29. Middle Name <b>David</b>		33. Type Employee ID Number		
30. Last Name <b>Smith</b>		SSN <input checked="" type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III) <b>Jr.</b>		Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1 <b>98 Dogwood Street</b>		40. Gender Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		
35. Mailing Address 2		41. Date of Birth <b>12/10/64</b>		
36. City <b>Ourtown</b> 37. State <b>Alabama</b> 38. Zip <b>12345</b> 39. Phone <b>334-234-3456</b>		42. Nbr of Dependents <b>0</b>		
43. Marital Status Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input checked="" type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>		44. Date Hired		
45. Occupation Description <b>Machine Operator</b>		46. Number of Days Worked Per Week <b>5</b>		
47. Wages <b>\$400</b>		49. Received Full Pay For Day of Injury? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
INJURY / TREATMENT				
51. Date of Injury <b>6/1/06</b>	52. Time of Injury <b>10:00 a.m.</b> <input checked="" type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>	53. Time Employee Began Work <b>8:00 a.m.</b> <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	54. Date Disability Began <b>6/2/06</b>	55. Date of Death
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
56. Site Address <b>123 Main Street</b>			62. Date Employer Notified <b>6/1/06</b>	
57. City <b>Ourtown</b> 58. State <b>Alabama</b> 59. Zip <b>12345</b>				
60. County <b>Johnson</b>				
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED, AND THE SPECIFIC INJURY. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet., injuring right ankle.)				
Employee was clearing a jam from his equipment. When the jam was cleared, the equipment started unexpectedly, pulling John's left hand past the cutting blade. This resulted in a severe cut to John's left hand.				
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP://DIR.ALABAMA.GOV/WC)				
64. Nature of Injury Code <b>40 - Laceration</b>		65. Part of Body Code <b>35 - Hand</b>		66. Cause of Injury Code <b>10 - Machine</b>
67. Initial Treatment First Aid By Employer <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor Clinic / Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Major medical/Lost time <input checked="" type="checkbox"/> Hospitalized Overnight <input type="checkbox"/>		68. Name of Treatment Facility <b>Med Care Inc.</b>		
		69. Address <b>567 Medical Park Drive</b>		
		70. City <b>Ourtown</b> 71. State <b>Alabama</b> 72. Zip <b>12345</b>		
73. Name of Physician or Other Health Care Professional <b>Dr. Ronald Evans</b>		74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		If so, 75. Date <b>6/2/06</b> 76. Time <b>a.m.</b> <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER				
77. Date Prepared <b>6/2/06</b>	78. Preparer's First Name <b>Robert</b>	79. Last Name <b>Turner</b>	80. Title <b>HR Manager</b>	81. Preparer's Telephone Number <b>334-987-6543</b>

• Employer's 10 digit Unemployment Compensation number as shown on State Quarterly Report

• Provide full name and last known address

• Use list to determine correct code or leave blank

• Thorough form completion by experienced staff member

• OSHA 300 log Column "A" (if applicable)

• Formally known as SIC Code

• Mandatory

• Date physician took employee off work

• Provide complete details regarding how the accident occurred including body part injured

The Employer's First Report of Injury is a state required form used by an employer to report work related injuries to their worker's compensation provider. These forms are available in multiple formats and are provided free of charge by Employer's Claim Management, Inc. This includes floppy disc, compact disc, hardcopy and on the ECMI website ([www.employersclaim.com](http://www.employersclaim.com)). To place an order request, please contact:

334-277-9395

800-392-1551

(FAX) 334-277-5134

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P.O. Box 5614  
Montgomery, Alabama 36103-5614