Alabama Retail Comp
Claims Reporting

After an on-the-job injury or illness

- In the case of an emergency, call 911 immediately.
- If the injury or illness is not an emergency, transport the injured employee to a medical care facility.
- Visit the medical provider lookup at **alabamaretail.org/comp/find-a-doctor** to locate the closest provider to the accident site.
- Request a post-accident drug and alcohol test within 36 hours of the accident (for workplaces with an applicable post-accident drug testing policy).
- Secure the scene of any serious accident for investigative purposes.
- Secure and save any equipment or materials that were involved in the incident or that caused the incident.
- Report the claim to Alabama Retail immediately following the injury.

Reporting an injury or illness

All employees should report on-the-job injuries or illnesses, no matter how minor, to the appropriate management personnel. Prompt claim reporting is essential and beneficial to all parties involved. State requirements established by the Alabama Department of Labor also mandate the prompt reporting of employee injuries.

- Complete and submit the State of Alabama Employer's First Report of Injury form immediately following the accident.
- Even if you think the claim is not legitimate or is potentially fraudulent, the First Report of Injury should be submitted. The report is non-committal; it is simply an alert to Alabama Retail that the claim requires investigation. Submitting the First Report of Injury does not bind an employer to paying a claim.
- Questionable claims should be reported to Alabama Retail as soon as possible to expedite the initial claim investigation.
- Accidents involving severe injury should be reported immediately via telephone at **800.239.5423**.

Alabama Retail Comp
Claims Reporting

Four convenient methods of claims reporting

- Online reporting is available 24 hours a day for your convenience at **alabamaretail.org/comp/report-claim/**
- The State of Alabama Employer's First Report of Injury form is available for download at **alabamaretail.org/froi/** Completed forms may be returned to the Claims Department by fax at **334.263.1976** or email to **claims@alabamaretail.org** within 48 hours of the injury.
- Claims may be reported by calling the Claims Department at **800.239.5423**, 8 a.m. to 5 p.m. Monday through Thursday and 8 a.m. to 4:30 p.m. Friday. *Be prepared to provide your ARC member number, business dba or corporate name, a summary of the accident and injury and the injured employee's name and contact information, including Social Security number.*
- For after-hours claims emergencies, call **800.239.5423** and press 3.

Employer authorized medical provider

The most important right an employer has under the Alabama Workers' Compensation Act is the right to choose an injured employee's authorized medical provider.

Alabama Retail Comp encourages all employers to aggressively utilize this critical right.

For a listing of medical providers in your area, visit **alabamaretail.org/com/find-a-doctor** or contact the Claims Department by phone at **800.239.5423** for assistance.

If initial treatment is performed by a medical provider not authorized by the employer or Alabama Retail, the employee may be asked to be evaluated by the employer's authorized medical provider. If additional medical treatment is necessary following the initial treatment, the employer's authorized medical provider should be consulted. Referrals for additional medical care should be directed to and approved through Alabama Retail's Claims Department.

Medical and prescription bills and records related to on-the-job injuries or illnesses should be forwarded promptly to Alabama Retail.

Reporting Work-Related Injuries

What you should do **after** an on-the-job injury or illness.

All employees should report work-related injuries, no matter how minor, to appropriate management personnel.

- ☑ Transport or send the injured employee to the nearest walk-in clinic or visit the medical provider lookup at www.alabamaretail.org to locate the closest provider to the accident site.
- ☑ Be sure to request a post-accident drug test (for workplaces with an applicable post-accident drug testing policy).
- ☑ Secure the scene of any serious accident for investigative purposes and the safety of other employees.
- ☑ Secure and save any equipment or materials that were involved in the incident or caused the injury.
- ☑ Complete an internal accident investigation report within 24 hours.
- ☑ Report the claim to Alabama Retail Comp within 48 hours following the injury. Prompt claim reporting can have a significant effect on the final cost of a claim.

Report an injury to Alabama Retail Comp

Download a copy of the Employer's First Report of Injury Form at alabamaretail.org/froi

Complete the form and return it to ARC in one of three ways:

Email claims@alabamaretail.org **Fax** 334.263.1976

Mail P.O. Box 240549, Montgomery, AL 36124-0549

If at any point you suspect fraud or malingering, please call ARC's claims department at (800) 239-5423 to notify an adjuster.

ARC ALABAMARETAIL COMP

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

RETURN COMPLETED FORM TO (334) 263-1976 OR CLAIMS@ALABAMARETAIL.ORG

CLAIM REFERENCE

FEDERAL TAX ID NUMBER (REQUIRED):

INSURED MEMBER NUMBER:

EMPLOYER

Employer Legal Name:
Physical Address 1:
Physical Address 2:
City: State: Zip:

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS:
Mailing Address 1:
Mailing Address 2:
City: State: Zip:

INSURER / FILING OFFICE

Insurer Name: *Alabama Retail Comp*
Mailing Address: *P.O. Box 240549*
City: *Montgomery* State: *AL* Zip: *36124*

Filing Office Phone: *(800) 239-5423*
Filing Office Fax: *(334) 263-1976*
Filing Office Email: *claims@alabamaretail.org*

EMPLOYEE / WAGES

First Name:
Last Name:
Last Name Suffix (Ex:. Jr., Sr., III):
Preferred Name:

EMPLOYEE SSN:

DATE OF BIRTH:

Mailing Address 1:
Mailing Address 2:
City: State: Zip:

Telephone:
Email:

Gender:
Male ☐
Female ☐

Occupation Description:

Employee Type:
W2 ☐ 1099 ☐

Date of Hire:

Wages:
Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐

Employee Status:
Full Time ☐ Part Time ☐

Received Full Pay For Day of Injury? Yes ☐ No ☐

Did Salary Continue After Accident? Yes ☐ No ☐

INJURY / TREATMENT

DATE OF INJURY:

Time of Injury:
a.m. ☐ p.m. ☐ unk ☐

Time Employee Began Work:
a.m. ☐ p.m. ☐

Date of Death:

Injury Occurred on Employer's Premises?
Yes ☐ No ☐
Date Employer Notified:

PLACE OF ACCIDENT, INJURY, OR EXPOSURE (if different than employer address):
Site Address:
City: State: Zip:
County:

DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED, AND WHAT BODY PARTS WERE AFFECTED (INCLUDING RIGHT OR LEFT SIDE):

Initial Treatment:
Minor Clinic ☐ Emergency Room ☐ Hospitalized >24 Hours ☐ No Medical Treatment ☐ First Aid by Employer ☐

Date of Initial Evaluation/Medical Treatment:

Name of Treatment Facility/Physician:
Address: City: State: Zip:
Telephone:

Has Injured Employee Returned to Work: Yes ☐ No ☐

Date Injured Employee Returned to Work:

Do you anticipate injured employee to miss more than 3 scheduled days of work? Yes ☐ No ☐

OTHER

Date Prepared:

Preparer's Full Name:
Job Title:

Preparer's Phone:
Preparer's Fax:
Preparer's Email:

SUPPLEMENTAL REPORT OF INJURY

PLEASE PROVIDE ANSWERS WHERE APPLICABLE

ADDITIONAL INJURY/TREATMENT DETAILS

IF MULTIPLE BODY PARTS WERE INJURED, PLEASE PROVIDE A LIST OF THE BODY PART, LEFT OR RIGHT SIDE, AND INJURY *(Example: Bruised Left Elbow)*:

Did you authorize any medical treatment: Yes ☐ No ☐ If yes, explain:	Is follow-up medical treatment needed/requested: Yes ☐ No ☐ If yes, explain:

Are you aware of any pre-existing injury(s) or health issues related to the injury or injured body part: Yes ☐ No ☐

If yes, explain:

WITNESSES / RESPONSIBLE PARTIES

Any witnesses to the accident/injury: Yes ☐ No ☐ Witness Name(s)/Phone(s):	Is there surveillance video of the accident/injury: Yes ☐ No ☐ ***If yes, please secure a copy of the video for future reference, if needed.***

Is a 3rd party responsible or potentially responsible for the accident/injury?	Yes ☐ No ☐
If yes, explain or provide the name of the responsible party(s):	
Was there a malfunction of any equipment or machinery that may have been in use when the accident/injury occurred?	Yes ☐ No ☐ N/A ☐

INVESTIGATION/SAFETY

Was the injured employee performing his/her normal job duties at the time of the accident/injury?	Yes ☐ No ☐
Do you have any concerns or suspicions that the accident DID NOT occur at work as reported by the injured employee?	Yes ☐ No ☐
Are you aware of any <u>written</u> safety policy or guideline that was violated which may have contributed to or caused the accident/injury?	Yes ☐ No ☐

CONTACT INFORMATION

Who is the best person(s) at the business to contact about this claim moving forward?

Name: Email:

Job Title: Phone:

Do you have any immediate questions or concerns about this accident/injury that you need to discuss with our office?

Yes ☐ No ☐ If yes, provide a brief explanation:

Please forward any related documentation or correspondence you have received related to this accident/injury.

RETURN COMPLETED FORM AND DOCUMENTATION TO
(334) 263-1976 OR CLAIMS@ALABAMARETAIL.ORG

INCIDENT INVESTIGATION REPORT

◯ Employee Injury ◯ Near Miss Incident

EMPLOYEE INFORMATION

Employee Name: _____ Today's Date: _____

SSN: _____ Age: _____ Gender: ◯ Male ◯ Female

Department: _____ Job Title: _____

Work Area: _____ Shift: _____

Length of Employment: _____ ◯ Full Time ◯ Part Time ◯ Contract Labor

Length at Present Job: _____

Supervisor's Name: _____ Supervisor's Signature: _____

ACCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ ◯ am ◯ pm

Date Reported: _____ Location of Incident: _____

Detailed narrative of how the incident occurred:

Description of Pictures Taken:

What was employee doing just prior to the incident/accident (job task, include any tools or machinery used):

Body part injured and type of injury (be specific):
If it is a near-miss incident, describe the potential injury:

Weather conditions at the time of the incident: _____

Visibility/Lighting (Ex: Poor, Spotlight, etc): _____

Type and condition of floor surface (Ex: Tile, wet): _____

PPE required for the job: _____

Was PPE being utilized: ◯ Yes ◯ No

Was there any damage to property or equipment? ◯ Yes ◯ No

Explain: _____

Name(s) of witness(es): _____ Phone# _____

Name(s) of witness(es): _____ Phone# _____

ALABAMA RETAIL COMP

INCIDENT INVESTIGATION REPORT (Page 2)

MEDICAL INFORMATION

First Aid Only: ◯ Yes ◯ No Doctor Visit Required: ◯ Yes ◯ No

Medical Provider Utilized: _____

CAUSES

PLEASE CHECK ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INCIDENT AND/OR INJURY

Direct / Immediate Causes (supervisor complete)

- ☐ Defective Tools / Equipment
- ☐ Unsafe work procedures
- ☐ Insufficient procedures
- ☐ Not following procedures
- ☐ Improvising / shortcuts
- ☐ Unaware of potential hazard
- ☐ Lack of safety devices
- ☐ Not employee's normal job
- ☐ Improper use of tools
- ☐ Proper tools not available
- ☐ Unauthorized equipment use
- ☐ Guard removed / guard needed
- ☐ Poor housekeeping
- ☐ Violated safety rule
- ☐ Not wearing proper equipment

Root Causes

- ☐ Employee unaware of hazard
- ☐ Complex procedures
- ☐ Unclear instruction
- ☐ Inadequate training
- ☐ Inadequate comprehension
- ☐ Lack of skill / knowledge
- ☐ Failure to recognize unsafe act
- ☐ Poor attitude
- ☐ Personality conflict
- ☐ Lack of training
- ☐ Job design / workstation layout
- ☐ Lighting
- ☐ Equipment Maintenance
- ☐ Weather condition (Rain, Heat)
- ☐ Excessive production pressure
- ☐ Communication error
- ☐ Lack of employee cooperation
- ☐ Other, please Explain

_____

CORRECTIVE ACTIONS

Recommended training, engineering control, or program/policy change:

Remedial training given:

Was action or should action be taken to prevent recurrence?

Corrective actions complete: ◯ Yes ◯ No If no, please explain: _____

Investigated by: _____ Date: _____

Reviewed by: _____ Date: _____

7265 Halcyon Summit Drive
Montgomery, AL 36117-3502
P.O. Box 240549 | 36124-0549
(800) 239-5423
alabamaretail.org

WAGE STATEMENT

Employer's (Company's) Full Legal Name: _____

Employer's Federal Tax Identification #: _____ Claim Number: _____

Claimant's Name: _____ Claimant's SS#: _____

Date of Employment: _____ Date of Injury: _____

Federal Tax Identification # under which claimant's wages are reported at year end:

- Are claimant's year end wages reported on a 1099? ☐ YES ☐ NO
- Are claimant's year end wages reported on a W2? ☐ YES ☐ NO

Does claimant work primarily inside the State of Alabama? ☐ YES ☐ NO

Claimant's Job Title & Job Description: _____

Please fill out claimant's wage information below:

	Pay Date	Pay Period From/To Dates		Gross Wages		Pay Date	Pay Period From/To Dates		Gross Wages
1					27				
2					28				
3					29				
4					30				
5					31				
6					32				
7					33				
8					34				
9					35				
10					36				
11					37				
12					38				
13					39				
14					40				
15					41				
16					42				
17					43				
18					44				
19					45				
20					46				
21					47				
22					48				
23					49				
24					50				
25					51				
26					52				

Total Wages Column 1: $ 0.00 ***Total Wages Column 2:*** $ 0.00

Grand Total of Wages: $ 0.00

**List the Amount of the employer's portion of health insurance premium paid for this employee: _____

**List the Amount of the employer's portion of life insurance paid for this employee: _____

**List the Amount of the employer's portion of disability insurance premium paid for this employee: _____

**Will Benefits be continued? ☐ YES ☐ NO

I certify that the above-named claimant receives wages from the Employer with the Federal Tax Identification Number listed above and all information is true and accurate.

Signature _____ Print Name _____ Title _____ Date _____

Phone Number _____ Email Address _____

NOTICE TO MEDICAL PROVIDER – AUTHORIZATION FOR TREATMENT

THIS IS A WORK-RELATED INJURY

This form must accompany an injured worker to the medical provider's office or emergency room.

WORKERS' COMPENSATION INFORMATION

Employee Name: _____ Today's Date: _____

Date of Accident/Injury: _____ Time of Accident/Injury: _____ am pm

Injury Description: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer Contact Name: _____

Contact Phone No.: _____ Fax No.: _____

Contact Email: _____

WORKERS' COMPENSATION BILLING INFORMATION

Coverage Type: **Workers' Compensation / Employers' Liability**

Policy No.: _____ Claim No.: _____

Insurance Carrier: **Alabama Retail Comp, P.O. Box 240549, Montgomery, AL 36124-0549**

Carrier Phone No.: **(800) 239-5423** Carrier Fax No.: **(334) 263-1976**

Carrier Email: **claims@alabamaretail.org**

Standard office visits and x-rays approved. Prior approval is required for all other treatment and/or referrals.

DRUG SCREEN INFORMATION

Is a drug screen required? ☐ **YES** ☐ **NO** ☐ **NON-DOT** ☐ **DOT**

When? **Post-Accident – within 32 hours of the accident**

Send Test Results to: **1. Alabama Retail Comp – Fax (334) 263-1976**

2. Employer

BREATH ALCOHOL TESTING

Is a breath alcohol test required? ☐ **YES** ☐ **NO**

When? **Post-Accident – within 8 hours of the accident**

Send Test Results to: **1. Alabama Retail Comp – Fax (334) 263-1976**

2. Employer

_____ _____

Approved by (Employer Representative Name & Job Title) Phone Number

Alabama Retail Comp
Workers' Compensation
PriorityRx Prescription Payment Authorization Form

Please keep this Authorization Form on file with script for auditing purposes.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form. Please submit the prescription using the processing information listed below.
Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

To transmit a prescription claim, please use the following information:

Processing information

Processor: EHO (Employer Health Options)
Bin #'s: 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

First Name: __ __ __ __ __ __ __ __ __ __ __ __ __

Group#: 70849 Sex: Male ☐ Female ☐

ID#/ SS#: __ __ __ __ __ __ __ __ __

D.O.B.: __ __ / __ __ / __ __ __ __

Prior Authorization #**: _____(retain this # for future use)**
PA#= DOI in YYMMDD format [ex: July 20, 2014 would be 140720]

Date Sent: _____

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	Date:
Physician's Name:	Phone #:

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to **Full Duty** as of _____(Date) with **NO RESTRICTIONS**.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) **WITH THE FOLLOWING RESTRICTIONS** through _____(Date):

Check applicable boxes and provide limitations/restrictions.	
☐ Lifting (Max weight in lbs) _____lbs.	☐ Walking _____ hours per day
☐ Repetitive Lifting _____lbs.	☐ Standing _____ hours per day
☐ Carrying _____lbs.	☐ Sitting _____ hours per day
☐ Pushing/Pulling _____lbs.	☐ Crawling _____ hours per day
☐ Pinching/Gripping _____lbs.	☐ Kneeling _____ hours per day
☐ Reaching overhead	☐ Squatting _____ hours per day
☐ Reaching away from body	☐ Climbing _____ hours per day
☐ Repetitive Motion Restrictions:	
☐ Other Restrictions:	

Physician's Name (Please Print):			
Physician's Signature:		Date:	

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:		Date:	

REFUSAL OF TREATMENT

EMPLOYEE NAME:		DATE:	

As of the date noted above I am notifying my employer of an injury that occurred on

(DATE): _____

- ☐ My supervisor did not receive notification of this incident.
- ☐ My supervisor did receive notification of this incident on (DATE): _____

This injury, (briefly describe condition) _____

_____

did occur during my normal scope and duties.

At this time I have been requested by my employer to be medically evaluated by a *preferred medical provider*. However, ***I decline to be medically evaluated for the above-noted condition.***

I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

PROVIDER:	
ADDRESS:	
PHONE:	

SHOULD THE CONDITION BECOME LIFE-THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE.

EMPLOYEE STATEMENTS

By signing this form, I acknowledge:

I have not sought medical treatment for this injury.

I understand that any treatment I elect to receive from an unauthorized physician or provider will not be covered under workers' compensation benefits and I will be responsible for any charges incurred for any unauthorized treatment.

I understand that if it is the policy of my employer to have a post-accident drug screen this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.

I have read the above information and agree it is factual and a true statement. I authorize any physician, hospital, or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_____ _____

Employee Signature **Supervisor / Witness Signature**

_____ _____

Date **Date**

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER Alabama Retail Comp

TELEPHONE NUMBER (800) 239-5423

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.