ARKANSAS WORKERS' COMPENSATION COMMISSION
324 Spring Street
P.O. Box 950
Little Rock, AR 72203-0950

TO: **Interested Parties**

FROM: **Carl Bayne**
Operations/Compliance

DATE: **November 20, 2012**

SUBJECT: **Form 1 Required Data, Effective January 1, 2013**

Following this notice you will find a Form 1 clearly marked showing what data is required, effective January 1, 2013.

In the past we have communicated with you that we "require" some data and "request" other. In order to simplify things, we are indicating for you only the data we require. Additionally we are providing for you explanations of what style of information will satisfy our requirements.

Please note that failure to provide any of the data marked on the accompanying Form 1 will cause your submission to be rejected.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA CASE NUMBER	REPORT PURPOSE CODE
1	3		
	JURISDICTION: 4	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): 5	LOCATION #	
INDUSTRY CODE / EMPLOYER FEIN: 2		PHONE #	

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
6	7 TO	9
	CHECK IF APPROPRIATE: ☐ SELF INSURANCE 8	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER: 10	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
11	12	13	14	

ADDRESS (INCL ZIP)	SEX: 15	MARITAL STATUS	OCCUPATION/JOB TITLE: 16
	M MALE; F FEMALE; U UNKNOWN	U UNMARRIED SINGLE/DIVORCED; M MARRIED; S SEPARATED; K UNKNOWN	EMPLOYMENT STATUS: 17
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: 18	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	AM / PM	LAST WORK DATE: 19	DATE EMPLOYER NOTIFIED: 20	DATE DISABILITY BEGAN: 21

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS: 22	PART OF BODY AFFECTED: 23
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

24	CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH: 25	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 OVERNIGHT HOSPITALIZATION 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE: 26	PHONE NUMBER: 27

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION ©IAIABC 2002

REQUIRED FORM 1 DATA

1. EMPLOYER NAME AND ADDRESS: Providing the name and address shown on the policy is helpful, but do not hesitate to include a DBA if it's appropriate. And, if it is a national employer, you will have an opportunity to, in box 5 (Employer's Location Address if Different) give us the local name and physical address of the employer.

2. EMPLOYER FEIN: Double check this for accuracy.

3. CARRIER/ADMINISTRATOR CLAIM NUMBER: Provide the claim number assigned by the Carrier or TPA actually handling this claim.

4. JURISDICTION: This is required only on EDI submission of your Form 1. For all claims other than by EDI submissions, we will accept it and enter it as an AR claim, unless some other state code is entered here, at which time we will reject your Form 1 filing.

5. EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): We require a physical location for where in injury/illness occurred. If you provide in Employer Name and Address (box 1) a P.O. Box, or if the injury/illness occurred at a location separate from the address listed in Employer Name and Address, you are required to provide this data, making sure it is a physical address.

6. CARRIER (NAME & ADDRESS): Provide the Carrier Name and Address as it is registered with the Arkansas Workers' Compensation Commission.

7. POLICY PERIOD: While self-insureds do not have a policy expiration date, if self-insurance is not marked in box 8, and this data is not provided, this Form 1 will be rejected.

Everyone else provide us the policy period for the policy in effect on the date of injury/illness.

8. SELF-INSURANCE: If a self-insured fails to properly identify themselves as self-insured, we will reject the Form 1 without a policy period.

9. CLAIMS ADMINISTRATOR (NAME & ADDRESS): Provide this information, in this block, even if the previously identified Carrier is handling the claim. We want the name and address in which the adjuster handling this claim is housed.

10. POLICY/SELF-INSURED NUMBER: Provide us the policy number which existed on the date of the injury/illness.

11. EMPLOYEE NAME: Double check the spelling. Provide at minimum the legal last and first names (unless the claimant's given name is "Bubba", do not send in a Form 1 indicating that his name is "Bubba").

12. DATE OF BIRTH: An accurate date of birth is required. Several have filed their Form 1 with dates that meet the format standard required to make it through the EDI screening, sometimes entering something such as 01/01/1901. If the date of birth is obviously fabricated, we will reject your Form 1.

13. SOCIAL SECURITY NUMBER: The full 9-digit Social Security Number is required on the Form 1.

14. DATE HIRED: This information is required only in Death cases. If, after filing your Form 1, the claimant dies, file an Amended Form 1 (clearly write "Amended" on the top of the Form and circle any data that is being added or changed), reporting the Date of Death and Date Hired.

15. SEX: This means gender: Male or Female. The Form 1 has a little box for Unknown, but we will not accept your Form 1 if you enter Unknown.

16. OCCUPATION/JOB TITLE: Please enter the primary occupation of the claimant at the time of his/her accident/incident/exposure.

17. EMPLOYMENT STATUS: The valid choices for Employment Status are:

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

18. DATE OF INJURY/ILLNESS: This is an absolute requirement, and is used on virtually all of the AWCC Forms that you will file on this claim. Please be sure that you're accurate on this date, as any form(s) that come in after your Form 1 with a different date of injury/illness are liable to be rejected.

19. LAST WORK DATE: It is not necessary that this be a complete work day. If an employee is injured and has to leave work, that day is his/her last work date. Without this date, we will reject your Form 1.

20. DATE EMPLOYER NOTIFIED: This is required only to the point that if you don't provide it for us, I will provide it on your behalf. If you leave this blank, I will not reject your Form 1, but I will use the Date of Injury/Illness as the Date Employer Notified.

21. DATE DISABILITY BEGAN: This is required only to the point that if you don't provide it for us, I will enter it on your behalf. If you leave this blank, I will not reject your Form 1, but our system is set up to default to the day after the Date of Injury/Illness as the Date Disability Began, if you don't give us a different date.

22. TYPE OF INJURY/ILLNESS: Ladies and gentlemen, following this instruction sheet, you will find the complete listing of injury/illnesses and the code for each.

23. PART OF BODY AFFECTED: Ladies and gentlemen, following this instruction sheet, you will find the complete listing of body parts and the code for each body part.

24. HOW INJURY OR ILLNESS OCCURRED: A short narrative, please. We want more than "tripped" or "crushed his finger". What we would like is more "carrying a box, stepped on a loose pipe, fell, dropping the box on his foot, breaking his foot".

25. IF FATAL, DATE OF DEATH: If this claim is a Death claim, we require the date of death to be reported on the Form 1. Additionally, you must report the Date of Hire (box 14).

If the claim did not begin as a Death claim, but becomes one, you are required to file an Amended Form 1 (clearly write "Amended" on the top of the Form and circle any data that is being added or changed), reporting the Date of Death and Date of Hire.

Too, when a Fatality occurs, you are required to file a Form D within 30-days of the Date of Death.

26. PREPARER'S NAME AND TITLE: We require the name and title of the adjuster handling this particular claim. So many have the employer's staff person who actually filled out the Form 1 to put their name and title here, but doing this is incorrect!

The proper place for the name and phone number of the employer's staff person who may actually fill out this Form 1 is the "Contact Name/Phone Number" box immediately below box number 18, in the Occurrence/Treatment section.

While we require the name and title of the adjuster handling this particular claim, we will not reject your Form 1 submission, even though the employer's staff person's name and title are written in here, IF you print your information on the bottom of the Form.

27. PHONE NUMBER: Similar to the note above, we want the phone number of the adjuster handling this claim. We do not ask for the phone number of the employer's staff person filling out this form, as we will never be contacting them. We do, however, want to be able to quickly contact you, so we require your direct phone number, or your main office phone number and your extension.

FINAL NOTE: "UNKNOWN" is never an acceptable entry on a Form 1. If it's a required data element, find the answer before submitting the Form 1. If it's not a required data element, and you don't know the answer, don't put anything in that box.

FORM 1, TYPE OF INJURY/ILLNESS AND CODES (Box 22 on Form 1)

Code	Type of Injury/Illness
01	NO PHYSICAL INJURY
02	AMPUTATION
53	SYNCOPE (SWOONING, FAINTING)
54	ASPHYXIATION
55	VASCULAR LOSS
58	VISION LOSS
59	ALL OTHER
60	DUST DISEASE NOC
61	ASBESTOSIS
62	BLACK LUNG
63	BYSSINOSIS
64	SILICOSIS
65	RESPIRATORY DISORDERS (GASES,FUMES,ETC.)
66	POISONING - CHEMICAL
67	POISONING - METAL
68	DERMATITIS
69	MENTAL DISORDER
70	RADIATION
71	ALL OTHER OCCUPATIONAL DISEASE
72	LOSS OF HEARING
73	CONTAGIOUS DISEASE
74	CANCER
75	AIDS
76	VDT-RELATED DISEASE
77	MENTAL STRESS
78	CARPAL TUNNEL SYNDROME
79	HEPATITIS C

Code	Type of Injury/Illness
80	ALL OTHER CUMULATIVE INJURIES
90	MULTIPLE PHYSICAL INJURIES
91	MULTIPLE INJURIES
03	ANGINA PECTORIS (CHEST PAIN)
04	BURN
07	CONCUSSION
10	CONTUSION
13	CRUSHING
16	DISLOCATION
19	ELECTRIC SHOCK
22	ENUCLEATION (REMOVE TUMOR)
25	FOREIGN BODY
28	FRACTURE
30	FREEZING
31	HEARING LOSS (TRAUMATIC ONLY)
32	HEAT PROSTRATION
34	HERNIA
36	INFECTION
37	INFLAMMATION
40	LACERATION
41	MYOCARDIAL INFARCTION (HEART ATTACK)
42	POISONING GENERAL
43	PUNCTURE
46	RUPTURE
47	SEVERANCE
49	SPRAIN
52	STRAIN

FORM 1, BODY PART AFFECTED AND CODES (Box 23 on Form 1)

Code	Body Part
00	UNDEFINED
10	MULTIPLE HEAD INJURY
38	SHOULDER(S)
39	WRIST(S) & HAND(S)
40	MULTIPLE TRUNK INJURY
41	UPPER BACK AREA (THORACIC AREA)
42	LOW BACK AREA INC:LUMBAR & LUMBO-SACRAL
43	DISC (TRUNK AREA)
44	CHEST INC: RIBS,STERNUM,AND SOFT TISSUE
45	SACRUM AND COCCYX
46	PELVIS
47	SPINAL CORD
48	INTERNAL ORGANS
49	HEART
50	MULTIPLE LOWER EXTREMITIES INJURY
51	HIP
52	THIGH
53	KNEE
54	LOWER LEG
55	ANKLE
56	FOOT
57	TOE(S)
58	GREAT TOE
60	LUNGS
61	ABDOMEN (INCLUDING GROIN)
62	BUTTOCKS
63	LUMBAR AND/OR SACRAL VERTEBRA
64	ARTIFICIAL APPLIANCE
65	UNKNOWN - INSUFFICIENT INFORMATION

Code	Body Part
66	NO PHYSICAL INJURY
90	MULTIPLE BODY PARTS INJURY
91	MULT SYSTEMS AND MULT BODY SYSTEMS
99	UNSPEC
11	SKULL
12	BRAIN
13	EAR(S)
14	EYE(S)
15	NOSE
16	TEETH
17	MOUTH
18	OTHER FACIAL SOFT TISSUE
19	FACIAL BONES
20	MULTIPLE NECK INJURY
21	VERTEBRAE
22	DISC (NECK AREA)
23	SPINAL CORD
24	LARYNX
25	SOFT TISSUE
26	TRACHEA
30	MULTIPLE UPPER EXTREMITIES
31	UPPER ARM (INC: CLAVICLE AND SCAPULA)
32	ELBOW
33	LOWER ARM
34	WRIST
35	HAND
36	FINGER(S)
37	THUMB