



Athens Administrators Claims Kit Arizona



Claims Kit Attachments

Employer's Report of Industrial Injury

Notice to Employees – *MUST BE POSTED*

Work Exposure to Bodily Fluids – *MUST BE POSTED*

Work Exposure to MRSA, Spinal Meningitis, or Tuberculosis – *MUST BE POSTED*

Employee Safety and Health Protection – *MUST BE POSTED*

To Report a Claim

Internet: www.athensadmin.com/reportclaim

User Name: athens1

Password: athens1

Telephone: 888-534-6375

eMail: reportclaim@athensadmin.com

Fax: 877-302-2872

To Find a Physician

Internet: www.corvel.com

Click on "Provider Lookup" on the top menu

Select "Search" from the "Find a Provider Panel" Menu

Select "Workers Compensation" in the "Select a Network" Dropdown

Questions

Edgar Castro, Senior Claims Examiner 800-347-7734

Mike Marin, Division Claims Manager 949-648-5842

Jamie Sanderson, Account Manager 925-648-1127

To request loss runs: lossruns@athensadmin.com



Employer's Report of Industrial Injury



**EMPLOYER'S REPORT
OF INDUSTRIAL INJURY**

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY**FOR OSHA PURPOSES ONLY**

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE		1. LAST NAME		FIRST	M.I.	2. SOCIAL SECURITY NUMBER *		3. BIRTH DATE	
4. HOME ADDRESS (NUMBER & STREET)				CITY		STATE	ZIP CODE	5. TELEPHONE	
6. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		7. MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED							
EMPLOYER		8. EMPLOYER'S NAME				9. POLICY NUMBER		10. NATURE OF BUSINESS (MANUFACTURING, ETC.)	
11. OFFICE ADDRESS (NUMBER & STREET)				CITY		STATE	ZIP CODE	12. TELEPHONE	
ACCIDENT		13. DATE OF INJURY OR ILLNESS		14. TIME OF EVENT <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		15. TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		16. DATE EMPLOYER NOTIFIED OF INJURY	
17. LAST DAY OF WORK AFTER INJURY		18. DATE OF RETURN TO WORK		19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED					
20. CLASS CODE ON PAYROLL REPORT		21. EMPLOYEE'S ASSIGNED DEPARTMENT		22. DEPARTMENT NUMBER		23. DID INJURY OCCUR ON EMPLOYER PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
24. ADDRESS OR LOCATION OF ACCIDENT				CITY		COUNTY	STATE	ZIP CODE	
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." <i>Examples:</i> "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."									
26. PART OF BODY INJURED				27. FATAL <input type="checkbox"/> YES <input type="checkbox"/> NO		28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH			
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL ADDRESS (STREET, CITY, STATE & ZIP CODE)							
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF HOSPITALIZED, HOSPITAL NAME ADDRESS (STREET, CITY, STATE & ZIP CODE)							
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON									
CAUSE OF ACCIDENT		32. WHAT HAPPENED? Tell us how the injury occurred. <i>Examples:</i> "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."							
33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? <i>Examples:</i> "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.									
34. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. <i>Examples:</i> "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."									
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS									
EMPLOYEE'S WAGE DATA		36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M.		38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY	
IMPORTANT		IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47		40. DATE OF LAST HIRE		41. WAS WORKER PAID FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, \$		42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR		44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE \$ PER HOUR DAY WEEK MONTH <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		45. IS EMPLOYEE FURNISHED <input type="checkbox"/> LODGING <input type="checkbox"/> BOARD <input type="checkbox"/> BOTH \$ VALUE					
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)						47. DOES EMPLOYEE CLAIM DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IMPORTANT		IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55		48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR		49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK			
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING INJURY FROM THRU \$				51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU \$					
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY		53. WAGE BEFORE INCREASE \$		54. WAGE AFTER INCREASE \$		55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY \$			
AUTHORIZED SIGNATURE		DATE		AUTHORIZED SIGNATURE				TITLE	

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.



Notice to Employees

MUST BE POSTED



TO BE POSTED BY EMPLOYER

POLICY NUMBER _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.



Work Exposure to Bodily Fluids

**MUST BE POSTED NEXT TO NOTICE TO
EMPLOYEES**



WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. NO LATER THAN TEN (10) CALENDAR DAYS after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. NO LATER THAN TEN (10) CALENDAR DAYS after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. NO LATER THAN EIGHTEEN (18) MONTHS after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

**KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES**

THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE



Work Exposure to MRSA, Meningitis or Tuberculosis

**MUST BE POSTED NEXT TO NOTICE TO
EMPLOYEES**

**WORK EXPOSURE TO METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA),
SPINAL MENINGITIS, OR TUBERCULOSIS (TB)**

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;
2. No later than 10 days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;
3. A diagnosis is made within the following time-frames:
 - a. For a claim involving MRSA, the employee is diagnosed with MRSA within two to ten days of the possible significant exposure;
 - b. For a claim involving spinal meningitis, the employee is diagnosed with spinal meningitis within two to eighteen days of the possible significant exposure; and
 - c. For a claim involving TB, the employee is diagnosed with TB within twelve weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.



Employee Safety and Health Protection Poster

**MUST BE POSTED
(8.5 x 14)**



EMPLOYEE SAFETY AND HEALTH PROTECTION

The Arizona Occupational Safety and Health Act of 1972 (Act), provides safety and health protection for employees in Arizona. The Act requires each employer to furnish his employees with a place of employment free from recognized hazards that might cause serious injury or death. The Act further requires that employers and employees comply with all workplace safety and health standards, rules and regulations promulgated by the Industrial Commission. The Arizona Division of Occupational Safety and Health (ADOSH), a division of the Industrial Commission of Arizona, administers and enforces the requirements of the Act.

As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795



Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational Safety and Health plan may do so at the following address:

U.S. Department of Labor – OSHA
3221 N. 16th St., Suite 100
Phoenix, AZ 85016
Telephone: 1-800-475-4020

PROTECCION DE SEGURIDAD Y SANIDAD PARA EL EMPLEADO

El Acta de Seguridad y Sanidad Ocupacional de 1972 (Acta) provee protección de seguridad y sanidad para los empleados en Arizona. El Acta requiere que cada patron les ofrezca a sus empleados un lugar de empleo libre de riesgos reconocidos que puedan causar daño o muerte. El Acta también requiere que los patrones y empleados cumplan con las normas, y los reglamentos de seguridad y sanidad promulgados por la Comisión Industrial. La ejecución de esta ley se lleva a cabo por la División de Seguridad y Sanidad Ocupacional, un brazo de la Comisión Industrial de Arizona.

Como empleado, Ud. tiene los derechos siguientes:

Tiene el derecho de notificar a su patron o a ADOSH sobre peligros en su lugar de trabajo. Puede pedir a ADOSH que mantenga su nombre confidencialmente.

Tiene el derecho de solicitar una inspección por parte de ADOSH si cree que existen condiciones peligrosas o poco saludables en su lugar de trabajo. Usted o su representante puede participar en la inspección.

Si cree que su patron lo ha discriminado por presentar reclamos de seguridad y sanidad o por ejercer sus derechos bajo el Acta, puede presentar una queja a ADOSH durante un plazo de 30 días después de la acción de discriminación. También tiene protección de discriminación bajo el acta federal de seguridad y sanidad ocupacional y puede archivar una queja con el Secretario de Labor de los Estados Unidos dentro de 30 días después de la discriminación alegada.

Tiene el derecho de ver las citaciones enviadas a su empleador. Su empleador debe colocar las citaciones en un lugar visible en el sitio de la supuesta infracción o cerca de el.

Tiene el derecho de protestar el tiempo dado para corregir una violación.

Tiene el derecho de recibir copias de su historial médico o de los registros de su exposición a sustancias o condiciones tóxicas y peligrosas.

Su empleador debe colocar este aviso en su lugar de trabajo.

La ley de seguridad y sanidad en el trabajo no aplica a aquellos patrones que emplean a servicio doméstico, a patrones de actividades marítimas (protegidos bajo OSHA), a patrones en actividades de energia atómica (protegidos bajo la Comisión de Energia Atómica), o a patrones en actividades mineras (protegidos por la Oficina del Inspector de Minas del Estado de Arizona). Para registrar una queja, reportar una emergencia o pedir asistencia de ADOSH, póngase en contacto con la oficina más cercana :

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795



Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478

Industrial Commission web site: www.ica.state.az.us

Nota: Personas que deseen registrar quejas alegando falta de adecuadez en la administración del plan de seguridad y sanidad ocupacional de Arizona pueden dirigir las a la siguiente dirección:

U.S. Department of Labor – OSHA
3221 N. 16th St., Suite 100
Phoenix, AZ 85016
Teléfono: 1-800-475-4020

First Fill Information

ATLAS



A Healthcare Solutions Company

Dear Injured Worker,

ScripNet has been selected by your employer to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply fill in the form below and present it at the pharmacy at the time your prescription is filled. This form guarantees that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, ScripNet has an extensive network of retail pharmacies. You may use your local pharmacy to process your prescription, or call our toll-free customer service number to identify additional network pharmacies in your area.

You may also visit our website at www.scripnet.com and use the pharmacy locator in the Resources section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our toll-free customer service number: 888.880.8562.



First Fill Form: Complete and take to your pharmacy

Bin #: 610621 **Group Number:** Not Required

Member ID:

Member Name: Injured worker's first & last name

Employer Name:

Date of Injury: Do not include anything in the person code field when processing the First Fill.

Pharmacy Help Desk: 888.880.8562

ADOSH
800 West Washington
Phoenix, AZ 85007