

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

- Items 2,7,8: Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.
- Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
- Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
- Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
- Items 32,33: Enter date in month-year format. Example: 02-56.
- Item 37: Enter the number of days or hours that make up a full work week for your employees.
- Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
- Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.



Service First Medical



First Fill Form

Client Name: Packard Claims Administration

S1 Medical has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. This form will serve to fill the initial injury-related prescriptions for up to 7 days. If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail, to be used to fill potential future prescriptions.

Injured Worker Name:

SS#:

Injured Worker DOB:

Injured Worker Phone:

Injured Worker Employer: Packard Claims

Date of Injury:

Injured Worker Address:

State:

City:

Zip:

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work-related injury/illness
- Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.

3. Instructions for the **PHARMACY**:

Please submit workers' compensation claims to **S1 Medical** using the following information:

BIN	PCN	Group Id	Member Id
610237	123119	PACKARD	Injured Worker SS#

Prescription(s) will fill for up to **7 Days**. If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at **(844) 700-5382**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (844) 700-5382

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input checked="" type="checkbox"/>
3. Social Security Number - - -	4. Home Phone ()	5. Date of Birth (m-d-y) - - -
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>	8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box City State Zip Code County		
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>		
11. Number of Dependent Children	12. Spouse's Name	
13. Doctor's Name		
14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code		

15. Date of Injury (m-d-y) - - -	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y) - - -
18. Nature of Injury* 20. How and Why Injury/Illness Occurred*	19. Part of Body Injured or Exposed*	
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>	22. Worksite Location of Injury (stairs, dock, etc.)* Street or P.O. Box County City State Zip Code	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County City State Zip Code		
24. Cause of Injury(fall, tool, machine, etc.)*		
25. List Witnesses		
26. Return to work date/or expected (m-d-y) - - -	27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name 29. Date Reported (m-d-y) - - -

30. Date of Hire (m-d-y) - - -	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly	37. Full Work Week is: Hours _____ Days _____	38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street City State Zip Code	
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company Lion Insurance Company		49. Policy Number WC71949	

50. Did you request accident prevention services in past 12 months?

YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X

Date _____

