

**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.

## MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

### Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.




Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit [tmesys.com](http://tmesys.com).

### Questions? Need Help?



**1-866-599-5426**



**WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM**

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CARRIER/TPA \_\_\_\_\_ EMPLOYER \_\_\_\_\_

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INJURED WORKER NAME \_\_\_\_\_

Please provide directly to Pharmacist

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SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF INJURY (YYMMDD) \_\_\_\_\_

**Notice to Cardholder:** Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: [tmesys.com](http://tmesys.com).

**Attention Pharmacists:** Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk 1-800-964-2531**

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PKCLFF		

**NOTE:** This First Fill card is only valid for your workers' compensation injury or illness.



### Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.



Optum  
PO Box 152539  
Tampa, FL 33684-2539

## HACEMOS MÁS SENCILLO...

### EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

#### Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.




La mayoría de farmacias y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?

¿Necesita ayuda?



**1-866-599-5426**



**WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM**

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PORTADORA EMPLEADOR

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NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

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NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

**Aviso para el titular de la tarjeta:** Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

**Attention Pharmacists:** Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk 1-800-964-2531**

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261		002538
RxPCN	CAL		Envoy Acct. #
GROUP	PKCLFF		

**NOTA:** Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



#### Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."



IMP14-1614-109-PKCLFF

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

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Unless the Division specifically requests a direct filling.

CLAIM # _____
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CARRIER'S CLAIM # _____
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### EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input 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 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*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
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	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 <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>	
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____	

