pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

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ELECTRONIC DATA INTERCHANGE

First Report of Injury

Transaction Title: (e.g. FROI)
Transaction Type: (e.g. Denial 04)

Jurisdictional Claim Number: (e.g.CLM-2012021312345)
Date Transaction Submitted to BWC: May 8 2012 01:30 PM

Employee Information	
First Name:	Middle Name:
Last Name:	Last Name Suffix:
Employee ID:	ID Type:
Date of Birth:	Date of Death:
Number of Dependents:	Employee Marital Status Code:
Mailing City:	
Mailing State Code:	
Mailing Postal Code:	
Gender Code:	
Mailing Primary Address:	
Mailing Secondary Address:	
Mailing Country Code:	
Phone Number:	
Date Of Hire:	
Occupation Description:	

Claim Information	
Jurisdiction Claim Number:	Jurisdiction:
Initial Date Disability Began:	Claim Type Code:
Type of Loss:	
Death Result of Injury Code:	
Claim Status Code:	
Late Reason Code:	
Accident Site County/Parish:	
Initial Return to Work Date:	
Initial Date Last Day Worked:	
Employment Status Code:	
Employer Paid Salary in Lieu of Compensation Indicator:	
Date Employer Had Knowledge of Date of Disability:	
Return to Work Type Code:	

Injury Information
Date of Injury:
Nature of Injury Code:
Time of Injury:

Injury Information
Part of Body Injury Code:
Cause of Injury Code:
Accident/Injury Description Narrative:

Denial Information
Full Denial Reason Code:
Denial Reason Narrative:

Insurer Information	
Insured Report Number:	Insured FEIN:
Insurer FEIN:	
Insured Name:	
Insured Type Code:	
Insurer Name:	

Claim Administrator Information
Claim Administrator Name:
Claim Administrator FEIN:
Claim Administrator Postal Code:
Claim Administrator Claim Number:
Claim Administrator City:
Claim Administrator State Code:
Claim Administrator Information/Attention Line:
Claim Administrator Primary Address:
Claim Administrator Secondary Address:
Claim Administrator County Code:

Employer Information	
Name:	Employer FEIN:
Physical Primary Address:	
Secondary Address:	
Physical City:	
Physical Postal Code:	
Physical Country Code:	

Employer Information
Contact Name:
Mailing Secondary Address:
Mailing City:
Mailing Postal Code:
Mailing State Code:
Mailing Country Code:
Mailing Information/Attention Line:
Policy Number Identifier:
Contact Business Phone: