Workers' Report of Injury

Information for Completing Workers' Report of Injury

A completed and submitted claim for workers' compensation benefits will be used to notify your employer's workers' compensation carrier or self-insured employer of your claim for workers' compensation benefits. If this form is submitted incomplete, there may be delays in processing the notification to the insurance carrier or self-insured employer to accept or deny the claim.

FAQ

Does the Industrial Commission of Arizona Claims Division (ICA) pay my claim?

- No, the Industrial Commission (ICA) Claims Division and Ombudsman office provide regulatory oversight and is available to assist you through the claims process. Please call us at 602-542-4661 or email us at Help@azica.gov, Ayuda@azica.gov or Claims@azica.gov for assistance.

How long does the Insurance Carrier or Self-Insured Employer take to accept or deny the claim.

- The Industrial Commission of Arizona will promptly notify the claim as soon as possible. From the date of notification, the Insurance Carrier of Self-Insured Employer have 21 days to investigate and make the decision on the claim.

When do I get paid for the time loss due to the accident?

- On a newly accepted claim for time loss (either light duty with loss of earnings or off work status), the first payment is due 21 days from the date of ICA's notification. There is a 7-day waiting period to qualify for benefits which, after 14 days, are retroactive to the first day.

What should I do if I am getting medical bills for my workers' compensation claim.

- When a claim is accepted for benefits, the medical benefits are payable immediately and you should have no out of pocket costs. Please contact your medical provider to ensure the correct insurance is billed for your treatment.

Right to choose physician

When an injury occurs, an employer has the right to have an injured worker seen by a doctor of the employer's choice one time. If you return to that physician a second time, that physician becomes your attending physician. After one visit to the employer's designated physician, you may select a physician of your choice. Exception: if your employer is self-insured and directs medical care you must follow the self-insured employer's directed care program. To determine if your employer is self-insured and directs medical care, you may contact the Industrial Commission of Arizona Claims Division at (602) 542-4661 or visit azica.gov/divisions/claims-division

Form available in alternative format: The Industrial Commission complies with the Americans with Disabilities Act of 1990. If you need this document in alternative format, contact Claims at (602) 542-4661.

Call Us
602-542-4661

Email Us
Help@azica.gov
Ayuda@azica.gov
Claims@azica.gov

INDUSTRIAL COMMISSION OF ARIZONA
Workers' Report of Injury

E-File visit www.azica.gov - Mail: Industrial Commission of Arizona PO BOX 19070 Phoenix AZ 85005 - Fax: 602-542-3373
Questions with the * are required, failure to complete may delay processing. Please call or email with any questions.

1. Injured Worker

First Name*:	Middle Initial:	Last Name*:
Last Four Social Security*:		Date of Birth*:
Gender: ◯ Male ◯ Female ◯ Nonbinary ◯ Prefer not to say		Legal Dependents at time of Injury*: ◯ Yes ◯ No
Dominant Hand: ◯ Right ◯ Left ◯ Ambidextrous		Marital Status*: ◯ Single ◯ Married ◯ Divorced
Telephone Number*: ###-###-####		Email Address:
Mailing Address*:		
City*:	State*:	Zip Code*:
Check to elect to receive notices and documents from the Industrial Commission by Email*: ☐		

2. Employment

Job Title*:		Date Hired at Employer*:
Employer Name* (from Paycheck Stub or Tax Document):		
Employer Address*:		
City*:	State*:	Zip Code*:
Employer Phone Number: ###-###-####		Supervisor Name*:
Supervisor Phone Number: ###-###-####		Supervisor Email Address:
Workers' Compensation Insurance Carrier:		Policy Number:
Base Rate of Pay Rate:		Per: ◯ Hourly ◯ Monthly ◯ Salary
Other earnings or other explanation of earnings from employer at time of injury:		
Did you have other employment in the last year? ◯ Yes ◯ No		

3. Injury

Date of Injury*:	Time of Injury:
Describe where and how the accident or cause of disab occurred (Limit 255 characters)*:	Describe what part(s) of body were injured (Limit 255 characters) *:
Did the injury include tooth loss or laceration on or about the face? ◯ Yes ◯ No	
Name of treating physician for the injury?	
Name of treating Clinic/Hospital for the injury?	
Who directed you to the treating physician?	◯ Myself ◯ Employer ◯ Insurance Carrier

4. Signature

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that pursuant to A.R.S. § 23-1028 it is a class 6 felony to make wilful, false statements to obtain compensation and that all my statements on this form are true, accurate and complete.

I hereby authorize each physician and person in the medical field and each hospital, clinic, or place rendering me any medical care, to provide The Industrial Commission of Arizona, my employer, the insurance carrier, and their authorized representative, any and all information, records and X-rays, regarding **my physical condition and treatment for this industrial injury**, to be used for a proper understanding of the case and a determination of the rights involved. I do not authorize the release of medical information from any source pertaining to conditions unrelated to the pending industrial claim. (see A.R.S. § 23-908(D))

Signature*:	Date*: