Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

RE: Employer:
Claim Number: PE
Date of Accident:

Dear :

Public Employee Claims Division (PECD) administers the workers compensation benefits for _____. PECD has accepted your injury of _____ as compensable and will be responsible for the authorized necessary and reasonable medical treatment associated with this accident.

The total disability rate is based upon sixty-six and two-thirds percent (66 2/3%) of your average weekly wage at the time the injury occurred. Based on the wage information we have received, you will be entitled to receive Temporary Total Disability (TTD) compensation in the amount of **$_____ per week/$____ per day.** (***OPTION*** This is the maximum TTD rate**.)** TTD compensation is based on a seven day week.

(OPTION if returned to work before 14th day)
Your seven day waiting period is _____ through _____. A State Warrant for compensation benefits in the amount **$_____** representing payment for the period of _____ through _____ has been ordered. You should receive the warrant in the next seven to ten business days.

(OPTION if RTW and no more TTD will be paid)
A State Warrant for compensation benefits in the amount **$_____** representing payment for the period of _____ through _____ has been ordered. You should receive the warrant in the next seven to ten business days.

(OPTION next four paragraphs if remains off work)
A State Warrant for compensation benefits in the amount **$_____** representing payment for the period of _____ through _____ has been ordered. You should receive the warrant in the next seven to ten business days.

Temporary Total Disability (TTD) compensation will continue to be paid to you on a bi-weekly basis until you are released to return to work by your physician or your healing period ends. We can only pay TTD benefits up to the date of your next doctor's appointment. If your appointment falls within the next two week period, you will be paid TTD through the date of the appointment. If you remain off work, you will receive the additional days due for that two week period once confirmation of your work status is received.

Please call me and your employer after each doctor's visit to provide an update on your status. You will also need to submit a work status note after each doctor's visit. If an off work note is not received before your next payment is due, the payment will be suspended until an off work note is received. Please fax the off work note to my attention at 501-371-2724.

When you are released to return to work, please call me or have your Human Resource Manager notify me as soon as possible to avoid overpayment.

Attached is information regarding Act 567 of 1975 advising you are entitled to supplement your workers' compensation benefits by utilizing your accrued sick leave. However, the Act prohibits you from receiving both workers' compensation benefits and sick leave in excess of your normal bi-weekly pay. Contact your payroll representative for more details.

Medical bills, including prescriptions drugs, as a result of your injury should be sent to PECD for review and consideration for payment. If you paid for your prescriptions, be sure to write that on the bill for reimbursement. If you are receiving bills do not assume we are receiving those bills also. Send them to me as soon as possible to avoid the provider turning the bill over to a collection agency for nonpayment. Mileage for trips that are for medical treatment is reimbursed at .43 cents per mile. Enclosed is a form you may use for this purpose. Also enclosed is a copy of the Form AR-2 we are filing with the Arkansas Workers' Compensation Commission for your records.

(OPTION next two paragraphs for subro claims)
This is a reminder that in accordance with Arkansas Code Annotated Sections 11-9-410 and 21-5-605(f)(2)(B) Public Employee Claims Division has a right of subrogation against any settlement or judgment which results from the above referenced accident and an absolute lien against same. This letter is to formally notify you of the above for protecting these rights.

To assist in the subrogation matter, please notify me when you have contact information from the third party. You should not settle your claim without advising the third party that the State has a lien against the claim or without contacting me with settlement information.

Please call me if you have any questions at the number listed below.

Sincerely,

Enclosures

cc: employer

IMPORTANT – READ CAREFULLY

Under Act 567 of 1975, an employee is entitled to supplement his/her workers' compensation benefits by utilizing his/her accrued sick leave time. However, the Act prohibits the employee from receiving both workers' compensation benefits and sick leave time in excess of his/her normal pay.

You should contact the payroll department at your place of employment before cashing the first check for workers' compensation benefits you received from this agency.

If you have already received sick pay benefits or annual leave benefits you can turn in your workers' compensation check and receive credit for the amount of sick leave/annual leave time the check represents.

Your payroll officer or timekeeper can explain this to you.

ANY WARRANTS RECEIVED FROM THIS OFFICE ARE FOR WORKERS' COMPENSATION RELATED BENEFITS. YOU MUST ADVISE BOTH THE EMPLOYER AND PECD OF ANY OTHER INCOME RECEIVED OR EARNED, INCLUDING FROM SELF-EMPLOYMENT, WHILE RECEIVING THESE BENEFITS. FAILURE TO DO SO MAY RESULT IN CIVIL ACTION AND/OR CRIMINAL LIABILITY.

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

Atten: Patient Accounts

Re: Employee:
Employer:
A/D:
Claim #:

To Whom It May Concern:

We have received the attached statement on the above claim. These charges are being denied for payment on the workers' compensation claim captioned above for the following reasons:

Claim denied
Charges not related to compensable injury
Unauthorized physician

Please update your records accordingly.

Sincerely,

Attachment

cc: employee

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

Re: Employee:
Employer:
DOB:
A/D:
Claim #:

Dear

This will confirm our phone conversation wherein I explained our office administers the workers' compensation claims for _____. After completing my investigation into the claim you filed for an injury on _____, it appears your claim did not arise out of or during course and scope of employment services. Therefore, I must respectfully deny your claim for workers' compensation benefits. Enclosed is the AR-2 that will be filed with the Arkansas Workers' Compensation Commission.

(Option)
We will cover the initial charges approved by your employer or Public Employee Claims Division only through the date of this letter.

You have the right to request a hearing before an Administrative Law Judge and to have an attorney represent you. You can contact the Arkansas Workers' Compensation Commission at 501-682-3930 or 1-800-622-4472 for information on how to request a hearing.

Let me know if you have any questions.

Sincerely,

Encl.

cc: employer

medical clinic

Public Employee Claims Division · Nathan Culp, Director
1200 W. 3rd Street, Little Rock, AR 72201-1904 · (501) 371-2700 · (866) 278-8066 · www.insurance.arkansas.gov
Fax: New Workers' Compensation Claims Only (501) 371-2733 · Other (501) 371-2724

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

Re: Employee:
Employer:
DOB:
DOI:
Claim #:

Dear Dr. :

This will acknowledge receipt of your _____ office note on Mr./Ms. _____. We would appreciate your advising if Mr./Ms. _____ has reached maximum medical improvement for his/her work injury and, if so, please provide that date.

(OPTION)
We need to know her current work status. Please advise if Mr./Ms. _____ has permanent restrictions resulting from her work injury

Also, please advise if Mr./Ms. _____ has any permanent impairment for this work injury. If you need to see him/her again to determine an impairment rating, this letter will serve as authorization for an evaluation. Impairment ratings must be based on objective and measurable findings as per the Fourth Edition of the AMA Guidelines. Please assess the rating to the _____.

For your convenience, you may complete the section below and return to me at the address shown on the bottom of the page.

Maximum Medical Improvement as of _____

(OPTION)
Permanent Work Restrictions No _____ Yes _____ Restrictions: _____

_____

Perm. Partial Impairment Rating _____% to the _____

Page(s)# _____ Table(s): _____

Doctor's Signature _____ Date: _____

Your assistance in this matter is most appreciated.

Sincerely,

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

Re: Employee:
Employer:
A/D:
Claim #:
WCC File #:

Dear :

We have received a report from Dr. _____ indicating you have reached maximum medical benefit as of _____. TTD benefits have been paid through _____. ***(OPTION:*** This resulted in an over payment of _____ days in the amount of $_____.)

Dr. _____ also stated you have a ____% Permanent Partial Impairment to your _____. This impairment rating entitles you to _____ weeks of PPD benefits at the weekly rate of $_____ for a total of $_____. (**OPTION:** Credit will be taken for the TTD overpayment mentioned above leaving a balance due of $_____.) PPD benefits are paid bi-weekly, and your first PPD payment will cover the dates _____ through _____. You should receive this check in the next few days. The PPD benefits will pay out on _____.

Please let me know if you have any questions.

Sincerely,

cc: Arkansas Workers' Compensation Commission
employer

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

VIA FAX:

Attn: HIPAA Rules do not apply to Workers' Compensation Injuries

Atten: Medical Records

Re: Employee:
Employer:
DOB:
A/D:
Claim #:

To Whom It May Concern:

Our office administers the workers' compensation for _____, and their employee, _____, has filed a claim. He/She has indicated he/she was treated in your facility in the past. Would you please forward to our office a **complete** copy of your records on Mr./Ms. _____? A copy of the signed release is provided.

Should there be a charge for these copies, please submit your invoice with your TIN number.

Your assistance in this matter will be most appreciated.

Sincerely,

Attachment

Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

VIA FAX:

Attn: HIPAA Rules do not apply to Workers' Compensation Injuries

Re: Employee:
Employer:
DOB:
A/D:
Claim #:

Dear Dr

I need further clarification on the above patient's injury that occurred on _____. Benefits cannot begin until this information is received. For your convenience you may check the correct response, sign and date the response, and fax to me at 501-371-2724.

Have you at any time since _____ palpated or observed muscle spasms while evaluating and/or treating the above-referenced patient?

_____ I did not palpate/observe muscle spasms.

_____ I did palpate/observe muscle spasms. What body part _____

Through diagnostics or observation, were acute objective findings of an injury noted? In workers' compensation "objective" means something not under the control of the patient. Examples of objective finding would be passive movement which is verifiable by some specific measure or test, or visual/physical injury.

Other acute objective findings _____

Signature Date

Your assistance is most appreciated.

Sincerely,