COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY PHONE NUMBER

EMPLOYEE:
MALE ☐ MARRIED ☐
FEMALE ☐ SINGLE ☐

NUMBER OF DEPENDENTS

DATE OF BIRTH
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS

FT = Full-time
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES ☐
NO ☐

TIME EMPLOYEE BEGAN WORK
AM ☐
PM ☐

TIME OF OCCURRENCE
AM ☐
PM ☐

344 1197-1

LAST DAY WORKED
MONTH DAY YEAR

DATE DISABILITY BEGAN
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
MONTH DAY YEAR

DATE RETURNED TO WORK
MONTH DAY YEAR

DATE OF HIRE
MONTH DAY YEAR

CONTACT FIRST NAME CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP

HOSPITAL NAME:

STREET

CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

STATEMENT OF WAGES (FOR INJURIES OCCURRING ON OR AFTER JUNE 24, 1996)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ _____

DATE OF INJURY (MM - DD - YYYY)

__ - __ - ____

WCAIS CLAIM NUMBER

_____

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

CONCURRENT EMPLOYMENT ONLY

Check if ☐ Primary employer OR

☐ Concurrent employer

INSTRUCTIONS

The Statement of Wages must be clearly completed in accordance with the Pennsylvania Workers' Compensation Act and uploaded in accordance with the provisions of the EDI Implementation guide when submitting certain EDI transactions. A copy must be sent to the injured employee.

The "average weekly wage" is used to determine the amount of weekly compensation wage-loss benefits payable under the Pennsylavania Workers' Compensation Act. A chart is available from the Bureau of Workers' Compensation to aid in determining the weekly compensation rate, online at www.dli.state.pa.us

CONCURRENT EMPLOYMENT

If the employee had more than one employer at the time of injury, a separate Statement of Wages form must be completed for each employer. Submit these forms together. Using #8 on the Primary Employer's form **only** (employer with whom the injury occurred): show the addition of the average weekly wages from all employers, show the combined average weekly wage to the right of the equal sign and show the appropriate workers' compensation rate. Check the Primary employer box for the Primary employer and the Concurrent employer box for all other employers.

Computation: Compute the appropriate items below for the employee to determine the average weekly wage.

	Wage		Weekly Board/ Lodging		Weekly Federal Reported Gratuities		Annual Bonus, Incentive or Vacation		Average Weekly Wage
1. If wages are fixed by the week:	_____	+	_____	+	_____	+	_____	= $	_____
2. If wages are fixed by the month:	_____	x 12 ÷ 52 +	_____	+	_____	+	_____	= $	_____
3. If wages are fixed by the year:	_____	÷ 52 +	_____	+	_____	+	_____	= $	_____

4. If paid in another manner, then complete the following for each of the last four consecutive periods of 13 calendar weeks preceding the injury.

	From	Through	Wages		Board/Lodging		Federal Reported Gratuities			Period Weekly Wage
1st Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
2nd Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
3rd Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
4th Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
							(Sum of three highest periods)		= $	_____
										Average Weekly Wage

Annual bonus, incentive and vacation $ _____ ÷ 52 = $ _____ (Weekly bonus, etc)

Sum of the highest three period weekly averages = $ _____ ÷ 3 + $ _____ (Weekly bonus, etc) = $ _____

5. If the employee has not been employed by the employer for at least three consecutive periods of 13 calendar weeks in the 52 weeks preceding the injury, use #4 above and put in the wages for any completed periods(s) of 13 weeks immediately preceding the injury and average the total amounts ..... = $ _____

6. If the employee worked less than a complete period of 13 calendar weeks and does not have fixed weekly wages: hourly wage rate $ _____ x the number of hours the employee was expected to work per week under the terms of employment _____ =$ _____ + weekly board/lodging of $ _____ + weekly federal reported gratuities $_____ + (annual bonus, incentive or vacation pay ÷ 52) $ _____ ..... = $ _____

7. For seasonal occupations, the average weekly wage is one-fiftieth of the total wages earned from all occupations during the 12 months immediately preceding the injury. Twelve months prior earnings $_____ ÷ 50 = $ _____ + weekly board/lodging $_____ + weekly federal reported gratuities $_____ ..... = $ _____

8. If the calculation in #7, or any other calculation above, does not fairly ascertain the earnings of the employee, the period of calculation is extended to give a fair calculation of their average weekly wage. Show this calculation here **OR** use the space below to show calculations for concurrent employment. = $ _____

_____

COMPENSATION PAYABLE PER WEEK: = $ _____

_____ _____

Employer/Defendant Representative's signature | Employer/Defendant Representative's name (typed/printed)

_____

Telephone

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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

WORKERS' COMPENSATION MEDICAL REPORT FORM

THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

Name of employee _____

Name of employer _____

Name of insurer _____

WCAIS claim number _____ Date of birth _____

Employee SS# XXX-XX-___ ___ ___ ___ Date of injury _____
Or
WC ID number _____

Date of report _____

Provider name _____

Provider address _____

Contact person _____ Telephone _____

Health care providers shall complete and submit the appropriate HCFA billing form and needed documentation to the employer. If the employer is covered by an insurer, the appropriate billing form and documentation is to be sent to the insurer. The LIBC-9 form and required accompanying documentation shall be submitted within 10 days of commencing treatment and at least once a month thereafter, as long as treatment continues. **If a provider does not submit the required medical reports in the prescribed format, the employer/insurer is not obligated to pay for such treatment until the required report is received by the employer/insurer.**

Documentation shall include (where pertinent) claimant's history, diagnosis, description of treatment and services rendered, physical findings and prognosis including whether or not there has been recovery enabling the claimant to return to work with or without limitations, and specific restrictions, if any, regarding return to work. Bills for follow-up visits should include progress/office notes to support the diagnosis and codes billed.

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports specifically requested by the employer/insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as confidential by the employer/insurer. The employer/insurer shall not be liable to pay for treatment until the required documents have been provided.

Listed on the reverse are guidelines for the completion of billing forms and submission of records.

BILLING FORM GUIDELINES:

Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form, or any successor forms required by HCFA/CMS. Forms must be signed or typed with the name of the provider. Name and signature (if signature is used) must match.

Cost-based providers shall submit a detailed bill including service codes and rev codes consistent with the service codes and rev codes submitted to the Bureau of Workers' Compensation on the detailed charge master.

Until a health care provider submits bills on one of the forms specified above, employers/insurers are not required to pay for the treatment billed.

MEDICAL REPORT FORM GUIDELINES:

This form must be submitted within 10 days of initial treatment and monthly thereafter, and must be accompanied by documentation to support the billing.

Suggested supporting documentation:

Physicians — Office notes
Physical/Occupational therapists — Daily treatment records/notes with physician referral
Pharmacies — NCD#, amount dispensed, RX#
DME vendor — Medicare/HCPC code, certificate of medical necessity
Chiropractors — Treatment notes
Ambulance providers — Medicare codes, notes/reports
X-ray/MRI facilities — Reports
Lab Facilities — Test results
Anesthesia services — ASA code, base/time units, anesthesia record
Hospitals — Records from area providing the service (e.g. emergency, outpatient surgery...)
Inpatient hospital admissions — H&P, discharge summary, operative report (if applicable)
CORFs & Rehabilitation Centers — Daily treatment notes, including physician orders
Ambulatory surgery centers — Notes and reports

General for all providers: Use the most appropriate and specific HCFA/CMS coding on billing. When using miscellaneous codes, include detailed description of services.

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