

First Report of Alleged Occupational Injury and Illness

NWCC Form 1
Revised 7-97

Filing Compliance

Information

&

Definitions

Nebraska Workers' Compensation Court
P.O. Box 98908
Lincoln, NE 68509-8908
402-471-6468
800-599-5155 (Nebraska Only)
www.nol.org/workcomp/

July 7, 1999

ADVISORY NOTICE

The Nebraska Workers' Compensation Court (NWCC) intends to require the electronic submission of first report of alleged occupational injury or illness filed by or on behalf of insurers, self insured employers, or risk management pools. Implementation is projected to begin on July 1, 2000. In the alternative, an implementation plan shall be approved by the court no later than July 1, 2000.

Currently there are two methods of filing work-related injuries reports as required by the Nebraska Workers' Compensation Act. The first is to file the First Report of Alleged Occupational Injury or Illness (NWCC Form 1), the paper form or hard copy, adopted July 1, 1997. The second is to file through Electronic Data Interchange (EDI), the electronic filing of the requirements established by the Nebraska Workers' Compensation Court. Voluntary EDI filings have been accepted since March, 1998.

The court's long-term strategy is to reduce paper handling through mandated EDI filings. In preparation for this mandate, the court will begin rejecting any paper form or hard copy (NWCC Form 1) that does not contain the mandatory and correct information that is required by EDI. Incomplete forms will be returned.

Enclosed is a copy of the court adopted NWCC Form 1 with general instructions listed on the reverse side and an instruction booklet detailing each field. Effective **January 1, 2000**, items in boldfaced type are mandatory fields and reports not including these fields will be returned as not accepted for reasons of incompleteness.

If you have any questions or need additional information, please do not hesitate to contact me at 402-471-6455 or 1-800-599-5155 (Nebraska only) or e-mail me at sdavis@wcc.state.ne.us.

Sincerely,

Su Perk Davis
Coordinator
Public Information Services

Enc.

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 7-97

Employer

Employer FEIN _____	UI# _____	SIC Code _____
Business Name(s) _____		Insured Name <i>(If different from employer name)</i> _____
Address _____		Employer's Location Address <i>(If different)</i> Location _____
City _____		
State _____ Zip Code _____ Phone _____		

Insurance Carrier

Carrier FEIN _____	Admin. FEIN _____
Name _____	Claim Administrator <i>(Name, address & phone number)</i> _____
Address _____	
City _____	
State _____ Zip Code _____ Phone _____	
Policy Number _____	
Policy Period: From _____ To _____	
Insurance Carrier/Self-Insured Code # _____	
Check if Appropriate	
Self Insured <input type="checkbox"/>	Carrier/Claim Administrator or Claim # _____
TPA <input type="checkbox"/>	Jurisdiction Claim # _____
Insured Report # _____	Jurisdiction _____

Employee

Name <i>(Last, First, Middle)</i> _____	Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/>	Salaried Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked Per Week _____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Address _____	Number of Dependents _____		Occupational Job Title _____	
City _____	Marital Status	Wage \$ _____	Occupational Code _____	
State _____ Zip Code _____ Phone _____	Married <input type="checkbox"/>	Hourly <input type="checkbox"/>	Date Employee Began Work-Related Duties _____	
Date of Birth _____	Separated <input type="checkbox"/>	Daily <input type="checkbox"/>	Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>	
Social Security Number _____	Unmarried <input type="checkbox"/>	Weekly <input type="checkbox"/>		
Date Hired _____	Unknown <input type="checkbox"/>	Bi-Weekly <input type="checkbox"/>		
		Monthly <input type="checkbox"/>		

Occurrence/Treatment

Date of Injury/Illness _____	Time Employee Began Work AM <input type="checkbox"/> PM <input type="checkbox"/>	Time of Occurrence AM <input type="checkbox"/> PM <input type="checkbox"/>	Last Work Date _____
Where Did Injury/Illness Occur? City _____ State _____ Zip _____		Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date Employer Notified _____	Date Disability Began _____	Date Returned to Work _____	If Fatal, Give Date of Death _____
Type of Injury/Illness <i>(Briefly describe the nature of the injury or illness; eg. lacerations to forearm)</i> _____			Nature of Injury Code _____
Part of Body Affected <i>(Indicate the part of the body affected by the injury/illness; eg. right forearm, lowerback)</i> _____			Part of Body Code _____
How Injury/Illness Occurred <i>(Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill)</i> _____			Case of Injury Code _____
Initial Treatment: No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/> Minor Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized More Than 24 Hours <input type="checkbox"/> Future Major Medical/Lost Time <input type="checkbox"/>			
Date Administrator Notified _____	Form Preparer's Name, Title and Phone _____		Date Prepared _____

General Instructions

Items in bold are mandatory fields. First Report of Injury or Illness (FRI) without this information will be returned.

Item—Definitions

Employer:

- Employer FEIN—the employer/insured's **Federal Employer's Identification Number**.
- UI#—the employer/insured's **Unemployment Insurance number**.
- SIC Code—**Standard Identification Classification code** which represents the nature of the employer's business.
- **Business Name—include all business names/doing business as (dba)**
- Address—the address of the employer's facility.
- **City—the city of the employer's facility.**
- **State—the state of the employer's facility.**
- Zip Code—the zip code of the employer's facility.
- Phone—phone number at the employer's facility.
- **Insured Name (if different from employer)—the named insured on the policy or the financially responsible self-insured employer.**
- Employer's location address (*if different*)—the address of the employer's facility where the employee was employed at the time of injury.
- Location #—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- **Carrier FEIN—carrier's Federal Employer's Identification Number.**
- **Admin. FEIN—administrator's Federal Employer's Identification Number.**
- **Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.**
- **Address—address of business entity.**
- **City—city of business entity.**
- **State—state of business entity.**
- Zip Code—zip code of business entity.
- Phone—phone number of business entity.
- **Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self-insurer responsible for administering the claims.**
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract.
- Insurance carrier/self insured code #.
- **Self insured/TPA—Is the entity a self insured employer or a third party administrator? Check one.**
- **Carrier/claim administrator claim #—identifies a specific claim within a claim administrator's claims processing system.**
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- **Name—give full name as shown on payroll. (Avoid initials if possible).**
- **Address—enter employee's current address and phone number to which communications about the case may be directed.**
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full pay for DOI (date of injury)—check one.
- Number of days worked per week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational job title—the primary occupation of the claimant at the time of the accident.
- Date employee began work-related duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- **Date of Injury—date on which the accident occurred.**
- Time employee began work—time employee began work for that date.
- Time of occurrence—time of day the injury occurred.
- Last work date—the last paid work day prior to the initial date of disability.
- **Where did injury/illness occur—complete county, state, and zip code.**
- Did injury/illness occur on employer's premises—check one.
- Date employer notified—the date that the injury was reported to a representative of the employer.
- Date disability began—if not disabled answer none and skip questions.
- Date returned to work—if injured has returned to work, complete this question.
- **If fatal, give date of death.**
- **Type of injury—describe the nature of injury.**
- **Part of body—the part of the body to which the employee sustained injury.**
- **How injury/illness occurred—a free form description of how the accident occurred and the resulting injuries.**
- Initial treatment—check one.
- Date administrator notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form preparer's name and phone.
- Date prepared—date form was actually completed.

Type or print neatly your response in ink.

Filing Compliance: *Information & Definitions*

This instructional booklet has been created to help your organization properly file First Report of Alleged Occupational Injury or Illness (NWCC Form 1) reports with the Nebraska Workers' Compensation Court. All reportable industrial accidents and occupational diseases are required to be reported to the court either by filing paper/hard copy reports or filing by electronic means.

1. Paper Filing:

Written reports must be submitted using the court-adopted First Report of Alleged Occupational Injury or Illness (NWCC Form 1) form. Information submitted should be printed or typed using black ink. (illegible reports will be returned). It is absolutely essential that you fill in all the mandatory information. Failure to complete the form may result in delayed processing and possibly penalties.

Necessity, function and conformity requires the court to accept only those NWCC Form 1s that contain the mandatory requirements for filing claims both electronically and on paper.

Mandatory Fields: The Court requires the carrier to provide the mandatory fields when filing on paper or when filing electronically on every First Report of Alleged Occupational Injury and Illness (FROI) filed with the Court. The Court will not process reports without the mandatory fields/data elements properly filled out and must pass all data information edits applied.

Conditional Data Elements: The information is normally optional, but becomes mandatory under conditions established by the Nebraska Workers' Compensation Court, e.g. If the injury resulted in a fatality then the date of death becomes mandatory. The data information must pass all edits applied. See the element requirements table and addendums for the specific conditions.

Optional: The data field/data element may not be sent if it is not available. If it is available it should be sent and edits will be applied, but unsuccessful edits do not cause paper reports to be returned or electronic reports filed to be rejected.

Mandatory Information on a First Report:

Several fields (pieces of information) have been declared as mandatory fields. These are shown in bold-faced type on the reverse side of the NWCC Form 1. Reports without this information will be returned. Mandatory fields include:

- Business Name, City & State
- Insured Name
- Carrier FEIN, Name, Address, City, State
- Administrator's FEIN, Name, Address, City, State (see page 3)
- Self Insured/TPA designation
- Carrier/Claim Administrator Claim # (see page 3)
- Employee Name, Address, Phone Number
- Employee Social Security Number
- Date of Injury
- Where the Injury Occurred
- Date of Fatal Injury
- Type of Injury
- Part of Body Injured
- Cause of Injury

Field Definitions

Asterisked items in boldfaced type are mandatory and must be completed or the form will be returned. Asterisked items not boldfaced are mandatory under certain conditions.

All sections of the NWCC Form 1 must be completed. There are many fields within the sections that are mandatory. Definitions for mandatory fields are in boldfaced type.

Enter all dates in MM/DD/YY format. For example 03/09/00, not March 3, 2000.

EMPLOYER:

Employer FEIN—The Federal Employer’s Identification Number of the employer where the employee was employed at the time of the injury/illness. A nine-digit number used to report federal withholding and FICA taxes.

UI#—The Unemployment Insurance number of the employer where the employee was employed at the time of the injury/illness. A ten-digit number assigned by the Nebraska Department of Labor for the purpose of reporting unemployed insurance taxes. Obtain from accounting or Human Resources department, whichever makes quarterly unemployment insurance payments.

SIC Code—The Standard Industrial Classification code which represents the primary nature of the employer’s business. If the employer is assigned multiple SIC codes, use the code that relates to the specific business operation for which the employee was employed at time of injury. If employer does not know the business’ SIC code, leave this blank.

* **Business Name**—The name of the employer where the employee was employed at the time of injury. Use employer’s name as it would appear in the telephone directory. Do not use initials unless they are part of the business name.

Do not abbreviate. Include all names which are used by the company including “doing business as” (d.b.a.).

Address, *City, *State, Zip Code—The address of the employer where the employee was employed at the time of the injury.

Phone—The telephone number of the employer where the employee was employed at the time of the injury. (Must include the area code.)

***Insured Name**—The named insured of the policy or the financially responsible self insured. Typically the parent company in a hierarchically structured organization when the employer is not the parent organization. The name that is carried on the employer’s workers’ compensation insurance policy.

Employer’s location address (if different)—The address, including city, state and zip code of the parent company in a hierarchically structured organization when the employer is not the parent organization.

Location—A code defined by the insured/employer which is used to identify the employer’s location where the employee was employed at the time of injury.

INSURANCE CARRIER:

***Carrier FEIN**—The Federal Employer’s Identification Number of the insurance carrier or self insured assuming the employer’s responsibility for workers’ compensation claim(s). A nine-digit number used to report federal withholding and FICA taxes.

***Admin. FEIN**—Is mandatory if Claim Administrator Name is present. The Federal Employer’s Identification Number is a nine-digit number used to report federal withholding and FICA taxes and is reported. If the claim is being administered by a Third Party Administrator, use the FEIN number of the third party administrator.

***Name**—The name of the Nebraska licensed business insurance company issuing a contract of workers’ compensation insurance and assuming financial responsibility. Do not list a group name of insurance companies, an insurance agent, claim servicing company or a third party administrator. If the employer has been approved to self insure in Nebraska by the court, state “self insured” in this field along with the name of the company as it appears on its self insurance certificate. (Report will be returned if this information is not submitted)

***Address, *City, *State, Zip Code**—The address of the Nebraska licensed business insurance company issuing a contract of workers’ compensation insurance and assuming responsibility.

Phone—The telephone number of the Nebraska licensed business insurance company issuing a contract of insurance and assuming responsibility.

***Claim Administrator (name, address, and phone)**—Mandatory unless Claim Administrator name and address is the same as the Insurance Carrier name and address in which case it becomes optional. This is the mailing address

and phone number of the claim administrator’s processing facility, third party administrator, risk management or self insured responsible for administering this claim.

Policy #—The number assigned to the contract/policy for that employer or association group.

Policy Period—The beginning and ending dates of the insurance contract/policy carried by the employer or association group to cover work-related injuries.

Insurance carrier/self insured code #—Either the insurance carrier number established and assigned by the National Association of Insurance Commissioners (NAIC) and used by state insurance departments or the self-insured number assigned by the Nebraska Workers’ Compensation Court.

***Self Insured/TPA**—Check appropriate box, if the organization is self insured (certified by the court as one who carries the risks arising from their operations and has the financial responsibility for the claim) or is a third party administrator assigned/contracted to adjust the claim for the carrier or self insured.

***Carrier/claim administrator claim #**—Mandatory unless business entity is Self Insured. Also mandatory if Self Insured uses a claim servicing company or third party administrator. This information is optional if the business entity is Self Insured and Self Administered but it is very useful. If it is available please provide it.

Insured Report #—A number used by the insured to identify a specific claim.

Jurisdiction—The governing body or territory whose statutes apply. Organizations filing the Nebraska Workers’ Compensation Court’s First Report of Alleged Occupational Injury or Illness must use “NE” for jurisdiction identification.

EMPLOYEE:

***Name**—The injured worker’s legally recognized name carried on the payroll or social security information. Avoid initials if possible. Do not use nicknames. *Note:* Enter double last names with a hyphen separator, no spaces to avoid last name editing errors. For name Suffix Jr, Sr, I, II, III, etc. enter last name comma and the suffix value, no spaces. If the employee changes his/her name, specify former and present name on all subsequent NWCC forms. (Report will be returned if this information is not submitted).

***Address, *City, *State, *Zip Code and *Phone**—The complete mailing address used by the injured worker at the time of injury. Mailing address must include the street address, city, state, and zip code and phone number.

Date of Birth—The date the injured worker was born. Use MM/DD/YY format.

***Social Security Number**—The 10-digit number assigned by the Social Security Administration used to identify the employee. Number must be entered as three digits, a dash, two digits, a dash, then four digits. (Report will be returned if this information is not submitted)

Date Hired—The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

Full Pay for DOI (date of injury)—Check “yes” if the injured employee received full wages for the date of the accident/injury or illness or no if the injured employee did not receive full wages for the date of the accident/injury or illness.

Number of days worked per week—The number of days per week that the employee is regularly scheduled to work.

Sex—Check the appropriate box indicating the gender of the injured employee.

Marital Status—Check the appropriate box indicating the marital status of the employee at the time of the injury.

Wage—The reported employee’s wage for the wage period prior to the injury. This amount may include commissions, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings.

Occupational job title—Identify the primary occupation of the employee at the time of the accident or injury. Give a clear description of the employee’s occupation. Do not use jargon that would be difficult to understand. Do not abbreviate with single letters; such as F.S.W. Instead, use Food Service Worker.

Occupational Code—If you are filing by paper and do not know the code, the court will code this for you.

Date employee began work-related duties—Date the injured worker began performing duties associated with his/her occupational job title. If the injured employee held different positions within the organization or changed duties, this is the date the injured employee began the duties/occupation that was held at the time of the injury/illness and not the date the injured employee was initially hired.

Employment Status—Check the appropriate box indicating full-time, part-time or other work status at the time of the injury with the covered employer.

OCCURRENCE/TREATMENT:

***Date of Injury**—The date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition; unless otherwise defined by statute. (Report will be returned if this information is not submitted).

Time employee began work—Time employee began his/her shift on the day of injury.

Time of occurrence—The time at which the accident occurred. Use 24 hour military time. May be left blank for occupational disease or cumulative injury.

Last work date—The last paid work day prior to the initial date of disability. Enter the last day the employee was paid in full. (If the disability began as a result of the employee leaving work at the end of the work day, then the last full day paid would be the day the injury occurred. If the employee was injured early in the work day and was not paid for the full day, then the last full day paid would be the prior work day. Use MM/DD/YY format.

***Where did injury/illness occur**—Indicate where the injury/illness occurred. Specify the exact location of the injury including the county, state and zip code.

Did injury/illness occur on employer's premises—Indicate whether the accident occurred at the employer's address.

Date employer notified—The date the employer or a representative of the employer was notified or knew of the injury or illness. Use MM/DD/YY format.

Date disability began—The *first* day on that the employee lost time from work due to the injury or disease. Use MM/DD/YY format.

Date returned to work—The date, following the most recent disability period, on which the employee actually returned to work, or was re-

leased to return to work. Use MM/DD/YY format.

***If fatal, give date of death**—If the employee died as a result of the accident or illness, then give the date of death. Use MM/DD/YY format. The date is required if the incident resulted in death and must be filed within 48 hours of the death.

***Type of injury**—Describe the injury sustained by the employee, i.e. amputation of the right index finger at second joint; fractured ribs; lead poisoning; dermatitis of left hand; second degree burns over right arm; etc. Be sure to include all injuries.

***Part of body**—Description of the part of the body to which the employee sustained injury, i.e. right index finger at second joint, ribs, internal organs, left hand, right arm above elbow, etc. Be sure to include all affected body parts.

***How injury/illness occurred**—A free form description of how the accident occurred and the resulting injuries. Describe fully the events which resulted in the injury or illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details which led or contributed to the injury or illness. Be specific in explaining how the incident took place.

Initial treatment—Check the appropriate box to identify the extent of medical treatment received by the employee immediately following the accident.

No Medical Treatment—injured employee did not seek medical attention.

First Aid By Employer—medical attention was given by employer's staff.

Minor Clinic/Hospital—injured employee was given off site medical attention.

Emergency Care—injured employee was treated at an emergency ward.

OCCURRENCE/TREATMENT (Continued):

Hospitalized More Than 24 Hours—injured employee was checked in and stayed in a hospital for more than 24 hours.

Future Major Medical/Lost Time—injured employee will require additional medical attention and will not return to work immediately.

Date administrator notified—The date the administrator who is processing the claim received notice of the injury or illness.

Form preparer's name and phone number—Person who completed the report and telephone number where he/she may be reached if there are any questions concerning the report.

Date prepared—The date the report was typed and completed. Use MM/DD/YY format.

The following fields do not have to be filled when submitting paper reports:

Occupational Code:

A code used to identify the primary occupation of the employee at the time of the accident or injury.

Nature of Injury Code:

The code which corresponds to the nature of injury sustained by the employee.

Part of Body Code:

The code which corresponds to the part of the body to which the employee sustained injury.

Cause of Injury Code:

The code which corresponds to the cause of injury.

Reminder:

Submit one original only

Do not submit duplicates

Facsimile copies will not be accepted

NOTES:

Advisory Notice:
First Report of Alleged Occupational Injury and Illness
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Definitions



Nebraska Workers' Compensation Court
State Capitol Building, Lincoln, NE 68509
800-599-5155 (toll free in Nebraska only)
402-471-6468 (Lincoln and out-of-state)
402-471-2700 (fax)
<http://www.nol.org/workcomp/>

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