

SELF-INSURED MEDICAL REPORT FOR 2009

THE INDUSTRIAL COMMISSION OF ARIZONA

This report is subject to verification by ICA auditors

SELF INSURED NAME: [Redacted]

PERIOD COVERED: [Redacted] To [Redacted]

INSTRUCTIONS ON SEPARATE PAGE

Costs Relating to Industrial Injuries

(fill in the bolded cells)

Line 1 Amount paid to doctors, nurses, hospitals, etc., for outside services rendered.

[Redacted]

Line 2 Amount paid for medications (Rx's and injections, etc.).

[Redacted]

Line 3 Amount paid for prosthetic devices (artificial limbs, braces, etc.).

[Redacted]

Line 4 Portion of Hospital expenses shown in "Hospital Report" (line 8) for industrial injuries. (incurred not directly paid)

[Redacted]

Line 5 Remuneration of medical personnel employed by the self-insured.

[Redacted]

Line 6 Amount paid for first aid supplies.

[Redacted]

Total medical costs for industrial-related cases during calendar year. (Total Lines 1 - 6)

[Redacted]

Line 7 Compensation paid to claimants (indemnity)

[Redacted]

Line 8 Excess premiums paid.

[Redacted]

Total expenditures for workers' compensation and occupational disease claims. (Total Lines 7-8)

[Redacted]

I certify this report is true and complete for the period stated.

Officer Signature: [Redacted]

Primary Email Address: [Redacted]

Officer Name: [Redacted]

Alternative Email Address: [Redacted]

Officer Title: [Redacted]

FAX Number: [Redacted]

Date of Officer Signature: [Redacted]

Primary Phone Number: [Redacted]

Name Title of Person completing form if different than above: [Redacted]

Alternative Phone Number: [Redacted]

[Redacted]

NAME OF TPA: [Redacted]

Date Form Completed: [Redacted]

Phone Number of TPA: [Redacted]

TPA FAX Number: [Redacted]

