S E L F - I N S U R E D MEDICAL R E P O R T F O R 2 0 10

THE INDUSTRIAL COMMISSION OF ARIZONA

This report is subject to verification by ICA auditors

SELF INSURED NAME:

PERIOD COVERED: To **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.	
Line 2	Amount paid for medications (Rx's and injections, etc.).	
Line 3	Amount paid for prosthetic devices (artificial limbs, braces, etc.).	
Line 4	Portion of Hospital expenses shown in "Hospital Report" (line 8) for industrial injuries. (incurred not directly paid)	
Line 5	Remuneration of medical personnel employed by the self-insured.	
Line 6	Amount paid for first aid supplies.	
	Total medical costs for industrial-related cases during calendar year. (Total Lines 1 - 6)	
Line 7	Compensation paid to claimants (indemnity)	
Line 8	Excess premiums paid.	
	Total expenditures for workers' compensation and occupational disease claims. (Total Lines 7-8)	
Line 9	**Total excess insurance reimbursements expected**	

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

Officer Signature:

Officer Name:

Officer Title:

Date of Officer Signature:

Name Title of Person completing form if different than above:

Date Form Completed:

Primary Email Address:

Alternative Email Address:

FAX Number:

Primary Phone Number:

Alternative Phone Number:

NAME OF TPA:

Phone Number of TPA:

TPA FAX Number: