SELF-INSURED MEDICAL REPORT FOR 2022

INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

This report is subject to verification by ICA auditors

SELF INSURED NAME:

PERIOD COVERED: To

Costs Relating to Industrial Injuries

(fill in the bolded cells)

Line 1 Total medical costs paid during calendar year 2022 for all industrial-related claims. **

** Include all claims from date of self-insurance authority through current calendar year-end. Medical costs include, but are not limited to: doctors, nurses, hospitals, etc.; Rx and injections; prosthetic devices; remuneration of medical personnel employed by self

Line 2 Compensation paid to claimants (indemnity) during calendar year 2022 for industrial-related claims. Include all claims from date of self-insurance authority through current calendar year end.

Line 3 Total premiums paid durihg calendar year 2022 for excess insurance.

Line 4 Total excess insurance reimbursements expected

Total premiums paid for excess insurance will be for Arizona claims only, for the current calendar year, and for all claims from time of self-insurance authorization. For example, if you are paying excess insurance premiums for claims incurred in 2012, include those premiums.

Line 5 Rehabilitation related expenses related to work injuries

Line 6 Medical Staff remuneration related expenses related to work injuries

Line 7 Nurse Case Management remuneration expenses related to work injuries

Line 8 Administrative staff remuneration related expenses

Line 9 Total Pharmaceutical expenses paid.

Line 10 Contract with a Third Party Administrator? ○ Yes ◉ No

Line 11 Total paid for each claim for administrative services

Line 12 Total paid for all administrative services during the year.

Line 13 Self-Administer WC Claims? ○ Yes ◉ No

Line 14 Total paid for dedicated staff.

I certify this report is true and complete for the period stated. By submitting this form electronically, I certify that I am an interested party or an authorized representative of an interested party. I further certify that I am authorized to sign this form and that all of the representations included in this form are true, accurate, and complete.

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:

Submit

NOTE: This report is a required information report on all claims paid for the calendar year, regardless of date of injury. Self-insurers will not be taxed on the amounts entered on this form.

If there are any questions, please contact the Tax Accountant at 602-542-1836 or e-mail at Taxes@azica.gov