pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

ELECTRONIC DATA INTERCHANGE
First Report of Injury

Transaction Title: (e.g. FROI)
Transaction Type: (e.g. Denial 04)

Jurisdictional Claim Number: (e.g.CLM-2012021312345)
Date Transaction Submitted to BWC: May 8 2012 01:30 PM

Employee Information	
First Name:	Middle Name:
Last Name:	Last Name Suffix:
Employee ID:	ID Type:
Date of Birth:	Date of Death:
Number of Dependents:	Employee Marital Status Code:
Mailing City:	
Mailing State Code:	
Mailing Postal Code:	
Gender Code:	
Mailing Primary Address:	
Mailing Secondary Address:	
Mailing Country Code:	
Phone Number:	
Date Of Hire:	
Occupation Description:	

Claim Information	
Jurisdiction Claim Number:	Jurisdiction:
Initial Date Disability Began:	Claim Type Code:
Type of Loss:	
Death Result of Injury Code:	
Claim Status Code:	
Late Reason Code:	
Accident Site County/Parish:	
Accident Site Postal Code:	
Initial Return to Work Date:	
Initial Date Last Day Worked:	
Physical Restrictions Indicator:	
Employment Status Code:	
Employer Paid Salary in Lieu of Compensation Indicator:	
Date Employer Had Knowledge of Date of Disability:	
Date Employer Had Knowledge of the Injury:	
Return to Work Type Code:	

Injury Information
Date of Injury:
Time of Injury:
Part of Body Injury Code:
Cause of Injury Code:
Nature of Injury Code:
Accident/Injury Description Narrative:

Denial Information
Full Denial Reason Code:
Denial Reason Narrative:

Insurer Information	
Insured Report Number:	Insured FEIN:
Insurer FEIN:	
Insured Name:	
Insured Type Code:	
Insurer Name:	

Claim Administrator Information
Claim Administrator Name:
Claim Administrator FEIN:
Claim Administrator Postal Code:
Claim Administrator Claim Number:
Claim Administrator City:
Claim Administrator State Code:
Claim Administrator Information/Attention Line:
Claim Administrator Primary Address:
Claim Administrator Secondary Address:
Claim Administrator County Code:

Employer Information
Name:
Employer FEIN:
Mailing Primary Address:
Mailing Secondary Address:
Mailing City:
Mailing Postal Code:
Mailing State Code:
Mailing Country Code:

Employer Information
Name:
Physical Primary Address:
Physical Secondary Address:
Physical City:
Physical Postal Code:
Physical Country Code:
Mailing Information/Attention Line:
Policy Number Identifier:
Contact Business Phone:

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