STATE OF ALABAMA

Public Education Employee Injury Compensation Board (PEEICB)

ACCIDENT REPORT EMPLOYEE STATEMENT

Health Insurance Coverage: ☐ PEEHIP ☐ VIVA ☐ Other _____

Date of Injury/Accident	Today's Date:	Time of Injury/Accident: ☐ a.m. ☐p.m. On break or at lunch at the time of accident? ☐ Yes ☐ No
Employee Name (Last, First, Middle Initial)	Date of Birth:	Social Security Number (Complete SSN not just the last 4).

Street Address:	City:	State: Zip:
Primary Phone Number	Email Address:	

Employment Status: ☐Full Time ☐ Part Time ☐Adult Bus Driver

Preferred method of contact by PEEICB: (choose one) ☐Email ☐ U.S. Postal Service Mail Delivery ☐ By Telephone

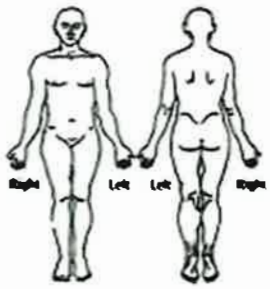
Job Title:	Name of Supervisor:	Date Supervisor Notified:

Describe the specific activity you were performing at the time the injury/accident occurred including exactly what happened to cause injury/accident.

Accident:

Injury/Body Part(s):

Exact location where injury/accident occurred:



Circle Injured Body Part

Were there any witnesses? ☐ Yes ☐ No	If yes, give names, addresses and phone numbers of each:

At the time of injury/accident, were you using any protective equipment (ex. Latex gloves, eye protection)?
If yes, list equipment used.

Have you previously had pain, treatment, diagnostic testing (x-rays, MRI, etc.) or injury to the same body part? ☐ Yes ☐ No
If yes, enter body part affected, date(s) of injuries and name(s) and address(es) of treatment provider(s).

Was injury/accident a result of an automobile accident? ☐ Yes ☐ No
If yes, obtain a copy of the police report of the accident and submit it to your supervisor as soon as possible.

I understand the intentional reporting of false information may disqualify me from receiving further PEEICB benefits and could expose me to penalties or criminal charges. I certify all information is correct to the best of my knowledge. I further understand that non-compliance with PEEICB Rules (i.e. failure to attend medical appointments as scheduled, failure to respond to requests for contact, failure to provide signed medical authorization forms, failure to cooperate with PEEICB staff, failure to comply with my physician's medical treatment plan, etc.) may progressively lead to suspension and/or termination.

Signature of Employee:	Date:	Daytime Phone:
Signature of supervisor reporting incident:	Date:	Daytime Phone:

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

Form FR-1
(Rev. 2026)

First Report of Injury

Please Submit This Form Along with the Employee's Accident Report Immediately.
PEEICB@MRM-LLC.COM or Fax: (205) 777-6097

1. Name of Injured Employee Last First MI	2. SSN ___ - __ - ____	3. Date of Birth __ / __ / ____	4. Sex ☐ M ☐ F
5. Employee Mailing Address No. and Street City or Town State Zip	6. Employee Phone Home Cell Work	Employee Work Hours: From: _____ To: _____ Normal Scheduled Days Off: ☐ MO ☐ TU ☐ WE ☐ TH ☐ FR ☐ SA ☐ SU	
7. Job Title			
8. Employee Email address	9. Employment Status ☐ Full Time ☐ Part Time ☐ Adult Bus Driver		
10. Employer	11. School District		
12. Employer Address	City or Town	State	Zip

13. Date of Injury	14. Date Employer Notified	15. Time of Injury __ : __ ☐ AM ☐ PM	16. On Employer's Premises? ☐ Yes ☐ No	17. Health Insurance Coverage PEEHIP ☐ VIVA ☐ Other ☐

18. Has the injury or illness resulted in medical treatment? ☐ Yes ☐ No

If yes, name and address of medical provider/facility.

19. Exact location where injury occurred include street address, building, room, parking lot, etc., if possible.

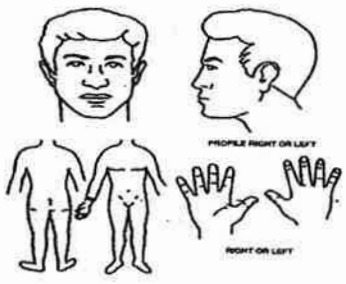
20. Was injury caused by a motor vehicle accident? ☐ Yes ☐ No If yes, provide copy of police report to PEEICB.

21. Was more than one person injured in this incident? ☐ Yes ☐ No If yes, provide name(s):

22. Describe exactly what the injured employee was doing and how the accident occurred.

23. Describe the injury (ies) received. Indicate if cut, bruise, sprain, strain, twist, pull, etc. (Give details below):

_____
_____
_____
_____
_____
_____



Indicate the body part(s) affected below and by circling on the body chart at left.

☐ Head	☐ Eye(s)
☐ Left Arm	☐ Right Arm
☐ Left Hand	☐ Right Hand
☐ Left Leg	☐ Right Leg
☐ Back	☐ Neck
☐ Left Foot	☐ Right Foot
☐ Left Knee	☐ Right Knee
☐ Left Ankle	☐ Right Ankle

☐ Other _____

24. Name all witnesses (Use additional paper as necessary):
Name _____ Daytime Phone _____
Name _____ Daytime Phone _____

I am the supervisor of the employee making the claim for PEEICB benefits and have filled out this First Report of Injury based on the information that has been reported to me. I certify that the above information is true and correct to the best of my knowledge.

25. Signature of individual reporting incident	Print Name and Email	Daytime Phone	Date

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

Provider Medical Reimbursement Information

Medical reimbursement for treatment of work-related injuries sustained by full-time public education employees and adult bus drivers depends on whether the employee is covered by **PEEHIP**.

1. Employees Covered by PEEHIP

For employees enrolled in **PEEHIP**, medical services related to an authorized on-the-job injury should be billed to **PEEHIP**.

The employee should:

- Present their BlueCross BlueShield of Alabama or VIVA Health medical insurance card at the time of service.
- Pay any applicable copayments or deductibles required under their health insurance plan.

All claims for covered medical services should be submitted directly to PEEHIP for payment.

2. Employees Not Covered by PEEHIP

For employees who are not covered by PEEHIP, authorized medical services related to an on-the-job injury are reimbursable through the **Public Education Employee Injury Compensation Board (PEEICB)**. The bill, along with all supporting documentation, should be submitted to Millennium Risk Managers at the address below or emailed to Bills-PEEICB@mrm-llc.com .

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238

If you have any questions, please call Millennium Risk Managers, 205-451-0812.

PLEASE PROVIDE THIS FORM TO THE DOCTOR'S OFFICE

(Rev. 2026)

STATE OF ALABAMA

Public Education Employee Injury Compensation Board (PEEICB)

COPAY & DEDUCTIBLE REIMBURSEMENT REQUEST

SUBMIT COMPLETED FORM TO:

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email to: PEEICB@mrm-llc.com
Fax: 205-777-6097

Health Insurance Coverage: ☐ PEEHIP ☐ VIVA ☐ Other

EMPLOYEE INFORMATION			EMPLOYER / SCHOOL INFORMATION
EMPLOYEE NAME:			School System/ Employer:
SSN / Employee ID			School / Location:
Mailing Address:			Department/School:
City:	State:	Zip:	Supervisor Name:
Phone Number:	Email:		Supervisor Phone:

INJURY / CLAIM INFORMATION	
Date of injury: Claim Number:	Have you received payment for this claim from any other source? ☐Yes ☐No If yes, please explain:

COPAY & DEDUCTIBLE REIMBURSEMENT EXPENSES

DATE OF SERVICE (mm/dd/yyyy)	MEDICAL PROVIDER / FACILITY (Doctor, Hospital, Clinic, Therapy, Pharmacy)	PURPOSE OF VISIT	COPAY/ DEDUCTIBLE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

REQUIRED DOCUMENTATION:
Please submit receipt of copay or paid deductible.

REIMBURSEMENT CALCULATIONS
A. Total Copay Expenses: _____
B. Total Deductible Expenses: _____
C. Total Reimbursement Request (A+B) _____

I certify that the information provided above is true and correct and that these expenses were incurred as a result of treatment for my compensable injury. I have not been reimbursed for these expenses from any other source.

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY		
Date Received:	Claim Number:	Amount Approved:
Reviewed By:	Check Number:	Date Paid:
Comments:		Initials:

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize any physician, hospital, clinic, healthcare provider, pharmacy, laboratory, rehabilitation provider, therapist, employer, insurance carrier, governmental agency, or any other public or private person or entity possessing records concerning my injury, illness, or medical treatment to release such records and information to:
Public Education Employees Injury Compensation Board
c/o Millennium Risk Managers, LLC

This authorization includes all medical, hospital, therapy, pharmacy, diagnostic imaging, laboratory, billing, psychological, psychiatric, vocational, rehabilitation, and other records reasonably related to my injury, illness, medical condition, treatment, or claim.

The information may be used by the Public Education Employees Injury Compensation Board, Millennium Risk Managers, LLC, its employees, agents, attorneys, consultants, nurse case managers, medical review vendors, bill review vendors, utilization review organizations, excess insurance carriers, reinsurers, and other entities involved in administering my on-the-job injury claim for claim investigation, medical management, benefit determination, payment of benefits, litigation, settlement, and other lawful claim administration purposes.

This authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) and applicable federal and state law. I understand that I may revoke this authorization at any time by providing written notice; however, any revocation shall not affect information previously released in accordance with this authorization.

Unless revoked earlier, this authorization shall remain effective until final resolution of my on-the-job injury claim, including all appeals, or five (5) years from the date signed below, unless otherwise provided by law.

A photocopy, scanned copy, faxed copy, or electronic copy of this authorization shall be considered as valid as the original. I authorize the release of the requested information and release any person or entity providing such information in good faith from liability for doing so as permitted by law.

I certify that I have read and understand this authorization and voluntarily sign it.

CLAIM INFORMATION
Claimant Name: _____
Date of Birth: _____
Last Four Digits of SSN: _____
Employer: _____
Date of Injury: _____
Claim Number: _____

SIGNATURE
Claimant Signature: _____
Printed Name: _____
Date: _____

Please submit to:
Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email: PEEICB@mrm-llc.com
Fax: 205-777-6097

STATE OF ALABAMA

PUBLIC EDUCATION EMPLOYEE INJURY COMPENSATION BOARD (PEEICB)

PEEICB Form MR-1
(Rev. 2026)

MILEAGE REIMBURSEMENT REQUEST

SUBMIT COMPLETED FORM TO:

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email to: PEEICB@mrm-llc.com
Fax: 205-777-6097

Reimbursement request is for an on the job injury: ☐ YES ☐ NO

EMPLOYEE INFORMATION

Employee Name: _____

SSN / Employee ID (Last 4): _____

Mailing Address: _____

_____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Email: _____

EMPLOYER / SCHOOL INFORMATION

School System / Employer: _____

School / Location: _____

Department / School: _____

Supervisor Name: _____

Supervisor Phone: _____

INJURY / CLAIM INFORMATION

Date of Injury: _____ Claim Number: _____

Have you received payment for this mileage from any other source? ☐ YES ☐ NO

If yes, explain: _____

MILEAGE LOG (Round Trip Mileage)

	DATE (mm/dd/yyyy)	MEDICAL PROVIDER / FACILITY (Doctor, Hospital, Clinic, Therapy, etc.)	FROM (Starting Location)	TO (Destination)	PURPOSE OF VISIT (Check One)	ROUND TRIP MILES
1.					☐ Treatment ☐ Test ☐ Other	
2.					☐ Treatment ☐ Test ☐ Other	
3.					☐ Treatment ☐ Test ☐ Other	
4.					☐ Treatment ☐ Test ☐ Other	
5.					☐ Treatment ☐ Test ☐ Other	
6.					☐ Treatment ☐ Test ☐ Other	
7.					☐ Treatment ☐ Test ☐ Other	
8.					☐ Treatment ☐ Test ☐ Other	
9.					☐ Treatment ☐ Test ☐ Other	
10.					☐ Treatment ☐ Test ☐ Other	

Code of Alabama 1975, Section 25-5-77(f), the employer shall pay mileage costs to and from medical and rehabilitation providers at the same rate as provided by law for official state travel.

MILEAGE REIMBURSEMENT SUMMARY

A.	Total Round Trip Miles	$ _____
B.	Approved Mileage Rate Per Mile	$ 0.76 (76¢ per mile)
C.	Total Reimbursement Requested	$ _____

EMPLOYEE CERTIFICATION

I certify that the information provided above is true and correct and that these expenses were incurred as a result of treatment for my compensable injury. I have not been reimbursed for these expenses from any other source.

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date Received:	Claim Number:	Amount Approved: $ _____
Reviewed By:	Check Number:	Date Paid:
Comments:		Initials:

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

How to File a Dispute

In the case of any dispute regarding benefits, the Employer, Employee, TPA, or the Board may refer the dispute to the Review Board or a Hearing Officer by providing written notice to the Executive Director within sixty (60) days of any adverse decision to the Employee, the Fund, or otherwise. In case of a dispute between Employer and Employee or between dependents of a deceased Employee and the Employer with respect to the right to benefits, or the amount thereof, the Employee may submit the controversy to the Review Board or request a hearing before a Hearing Officer.

A dispute shall be initiated by filing a Notice of Dispute with the Fund, stating the determination challenged, the relief sought, and whether the party requests a Hearing Officer or Review Board. The request for review must be in writing and directed to the Executive Director, must describe with particularity the issue or issues in dispute, and must be received no later than sixty (60) days from the date on which the Employee was notified of the disputed decision. Calculation of the sixty (60) days shall be calendar days, not "working days".

The Notice of Dispute Form needs to be completed and submitted to both the Public Education Employee Injury Compensation Board and Millennium Risk Managers by email at info@peeicb.alabama.gov and peeicb@mrm-llc.com or by mail to the following addresses.

Public Education Employee Injury Compensation Board
Attn: Executive Director
105 Tallapoosa Street, Ste. 307
Montgomery, AL 36104

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

Notice of Dispute

Person filing the notice: Employee ☐ Employer ☐ TPA ☐ Date:_____
Name: _____ Date of Disputed Decision: _____
Address: _____
Phone Number: _____ Email: _____
School/School System name: _____
Address: _____
Phone Number: _____ Email: _____
Request is for: Review Board ☐ or Hearing Officer ☐

Describe in detail the issue or issues to be considered including the determination being challenged and the relief sought. (Use additional pages if necessary)

_____
_____
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Please submit this form within 60 days of the disputed decision by email to both email addresses info@peeicb.alabama.gov and peeicb@mrm-llc.com or by mail to the following locations.

Public Education Employee Injury Compensation Board
Attn: Executive Director
105 Tallapoosa Street, Ste. 307
Montgomery, AL 36104

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238