PEEICP

PUBLIC EDUCATION EMPLOYEE INJURY COMPENSATION PROGRAM

EMPLOYEE QUICK REFERENCE GUIDE

ONE INJURY. ONE CALL. ONE TEAM.



WHAT TO DO IF YOU'RE INJURED

1. Report the Injury

Complete an Employee Accident Report and report your work-related injury immediately. Submit the report to your supervisor or executive officer as soon as possible, but no later than five (5) working days after the injury.

2. Submit the First Report of Injury

Call the Nurse Triage Line to initiate the First Report of Injury. If Nurse Triage is not used to initiate the First Report of Injury, your supervisor or executive officer must complete the First Report of Injury and submit it, along with the Employee Accident Report, to Millennium Risk Managers.

3. Claim Review

Once both reports are received, Millennium Risk Managers will verify the claim information and discuss the next steps with you.

4. Obtain Medical Treatment

Follow medical treatment instructions based on your coverage. Employees covered by PEEHIP must use an authorized treating physician covered by PEEHIP. Employees not covered by PEEHIP will be directed to an authorized medical provider.

5. Payment for Medical Treatment and Pharmacy Benefits

PEEHIP employees should present their medical insurance card and Provider Reimbursement Form and may request reimbursement for eligible copays and deductibles. Employees not covered by PEEHIP will have eligible medical expenses paid directly by the Program.

6. Mileage Reimbursement

Mileage reimbursement is available for travel to and from authorized medical appointments. Submit the Mileage Reimbursement Form and appointment documentation within 12 months.

7. What to Bring to Your Medical Appointment

Bring your Authorization for Release of Medical Records, medical insurance card (if applicable), and Provider Reimbursement Form.

REPORTING TIMELINE

Report your on-the-job injury as soon as possible. The Employee Accident Report must be completed within five (5) working days. Prompt reporting helps ensure timely medical treatment.

IMPORTANT CONTACTS

MAIN PHONE NUMBER
205-451-0812
General main number for Millennium Risk Managers

GENERAL EMAIL
PEEICB@mrm-llc.com
For all correspondence to MRM

BILLS EMAIL
Bills-PEEICB@mrm-llc.com
For all medical bills, legal bills, vendor bills, or any bills to be paid from the FUND

CLAIM FORMS FAX NUMBER
205-777-6097
Fax both Accident & Injury Reports

NURSE TRIAGE LINE
Initial Claim Reporting Only
1-800-27-CLAIM
(1-800-272-5246)
Available 24/7/365

FORMS YOU MAY NEED

- First Report of Injury
- Accident Report Form
- How to File an On-the-Job-Claim
- Medical Reimbursement Instructions
- Medical Records Release
- Co-Pay/Deductible Reimbursement Form

Emergency Medical Care: If the injury is life-threatening or requires emergency treatment, call **911** or seek immediate emergency medical care first. **Report the injury to your supervisor as soon as reasonably possible afterward.**

VISIT OUR WEBSITE
https://peeicb.alabama.gov

WE'RE HERE TO HELP
205-451-0812

The Public Education Employee Injury Compensation Program (PEEICP) is administered in accordance with the Maryann Leonard Educators' On-the-Job Injury Act.

STATE OF ALABAMA

Public Education Employee Injury Compensation Board

How to File an On-the-Job Injury Claim

Emergency Medical Care: If the injury is life-threatening or requires emergency treatment, call **911** or seek immediate emergency medical care first. Report the injury to your supervisor as soon as reasonably possible.

If you are a full-time public education employee or an adult bus driver and sustain a work-related injury on or after **October 1, 2026**, follow the steps below to file a claim under the Public Education Employee Injury Compensation Program (PEEICP).

1. Report the Injury

Complete an **Employee Accident Report**. Report every work-related injury immediately, regardless of severity. The Employee Accident Report must be completed within five (5) working days from the date of injury, prompt reporting helps ensure timely medical care and accurate claim administration. Submit the completed report to your immediate supervisor or the executive officer of your school system.

After reporting your injury, you are encouraged to use the **Nurse Triage Program**. The average call lasts approximately **13 minutes**. During the call, a registered nurse will:

- Ask questions about your injury.
- Recommend the appropriate next steps for medical treatment.
- Complete and submit the **First Report of Injury** on your behalf.

Both the injured employee and the employee's supervisor (or another member of school leadership) should participate in the call.

Nurse Triage Hotline
Phone: 1-800-272-5246
Availability: 24 hours a day, 7 days a week, 365 days a year

After completing the call, you must still submit your **Employee Accident Report** to the programs third-party administrator (TPA) Millennium Risk Managers.

Email: PEEICB@mrm-llc.com
Fax: 205-777-6097

If you choose not to use the Nurse Triage Program, follow the procedures outlined in Step 2.

2. Submit the First Report of Injury

If the Nurse Triage Program is not used, your immediate supervisor or the executive officer of your school system must complete the **First Report of Injury** and submit it along with the **Employee Accident Report** to the Public Education Employee Injury Compensation Program's third-party administrator (TPA).

Reports may be submitted by email, fax, or mail.

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

3. Claim Review

Once the TPA receives both the **Employee Accident Report** and the **First Report of Injury**, you will be contacted to verify the claim information and discuss the next steps.

4. Obtain Medical Treatment

Medical treatment procedures depend on whether you are covered by **PEEHIP**.

- **Employees covered by PEEHIP (through Blue Cross/Blue Shield or VIVA HEALTH):** Unless it is a true emergency, you must use a network physician for treatment. The TPA or Triage nurse can assist in identifying a network physician and can assist in coordinating treatment. You can also call your plan's customer service department.
- **Employees not covered by PEEHIP:** The TPA will direct you to an authorized medical provider (a physician within the TPA's network) for treatment of your work-related injury.

Third-Party Administrator (TPA)
Millennium Risk Managers
Phone: 205-451-0812

5. Payment for Medical Treatment & Pharmacy Benefits

Employees Covered by PEEHIP

Present your BlueCross BlueShield of Alabama or VIVA Health medical insurance card and **Provider Reimbursement Form** at each medical appointment and pay any required copayments or deductibles under your health insurance plan.
Copayments and deductibles are reimbursable through the Public Education Employee Injury Compensation Program. To request reimbursement, submit the following to the TPA within **12 months** of the date the expense was incurred:

- Copay and Deductible Reimbursement Form
- Required supporting documentation

Employees Not Covered by PEEHIP

The Public Education Employee Injury Compensation Program will pay for authorized medical treatment directly. You will not be responsible for copayments or deductibles.
To help avoid billing delays or confusion, all injured employees should provide the medical provider with a **Provider Reimbursement Form** at the time of their appointment.

Pharmacy Benefits

Much like medical treatment outlined previously pharmacy benefits are covered under the program as well. For injured employees covered by PEEHIP through either Blue Cross Blue Shield or VIVA HEALTH, your prescriptions will be covered by PEEHIP in the same manner that your prescriptions are currently filled. If you incur a copay associated with the

prescribed medication that copay is reimbursable through the PEEICP by completing a Copay and Deductible Reimbursement Form within **12 months** of the date the expense was incurred.
For injured employees not covered by PEEHIP pharmacy benefits will be managed by Millennium Risk Managers (TPA) and there will be no out-of-pocket expenses associated with your prescribed medications.

6. Mileage Reimbursement

All covered employees are eligible for mileage reimbursement for travel to and from authorized medical appointments related to their work-related injury.
To receive reimbursement, submit the following to Millennium Risk Managers (TPA) within **12 months** of the date of travel:

- Mileage Reimbursement Form
- Documentation from the medical appointment for which reimbursement is requested

7. What to Bring to Your Medical Appointment

Bring the following items to each authorized medical appointment:

- Authorization for Release of Medical Records
- BlueCross BlueShield of Alabama or VIVA Health Medical Insurance Card (if applicable)
- Provider Reimbursement Form

Questions?

If you have questions about filing an on-the-job injury claim, please contact
Millennium Risk Managers.
Phone: 205-451-0812
Email: PEEICB@mrm-llc.com

If you receive a medical bill related to your work injury, do not ignore it. Forward it to Millennium Risk Managers immediately for review and assistance.

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

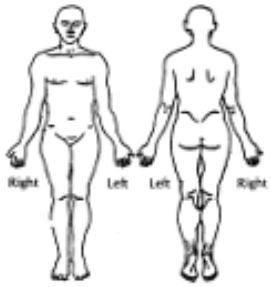
Job Title:	Name of Supervisor:	Date Supervisor Notified:

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.

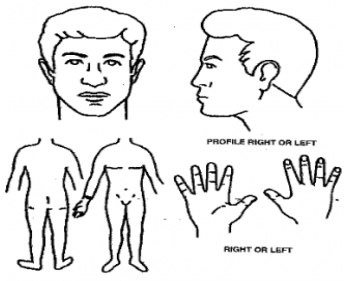
20. Was injury caused by a motor vehicle accident? ☐ Yes ☐ No If yes, provide copy of police report to PEEICB.

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

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