# Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

*Report Online*

**To use the app, you will first need to register on the Great American Insured Portal**

**https://insuredportal.gaig.com**

1. **Click the Request Access link**
2. **Complete the Policyholder Registration form**
3. **Confirm the Insured Portal system generated "Identity Verification" email**

***Preregistration Required***

*Call our reporting center*

**877-836-1555**

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

Great American Insurance Group, 301 E. Fourth St., Cincinnati, OH 45202. Policies are underwritten by Great American Insurance Company, Great American Assurance Company, Great American Alliance Insurance Company, Great American Insurance Company of New York, Great American Security Insurance Company and Great American Spirit Insurance Company, authorized insurers in all 50 states and DC. The Great American Insurance Group eagle logo and the word marks Great American® and Great American Insurance Group® are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 4642-ALT-1 (5/20)

**Accident Information:**

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

**Employee Information:**

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

**Medical Provider Information**:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

*After you report a claim, the Claim Reporting Center:*

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

# Establishing a Managed Care Panel

Great American Insurance Group has contracted with Procura/Optum to provide customizable Physician and Clinic Networks for our insureds. These networks provide injured workers with industry leading care and medical treatment at significant cost savings to employers.

Most states have specific guidelines governing the right for an employer or employee to direct care in the event of an industrial injury. Some states require the establishment of a Medical Panel for the initial treatment of work-related injuries. Due to the significant cost savings associated with Medical Panels, Great American – Alternative Markets recommends that employers establish medical Panels for all work locations.

**Mandatory Panel States: GA, PA, TN, VA**

**Medical Provider Network (Opt-in): California**

Medical Panels will need to be established BEFORE you have your first claim. Please fill out the below questionnaire listing all work locations and send to:

**AlternativeMarketsAccountServices@GAIG.COM**

Once received, you will be contacted by a member of our account services team to discuss the needs of your business and how to best construct the medical panel that will deliver appropriate coverage to your employee population.

## Questionnaire

**Named Insured:** ______________________________

**Location:** ______________________________

**Address:** ______________________________

**Contact name:** ______________________________

**Contact phone number:** ______________________________

**Employee count:** ______________________________

**Current network:** ☐ Yes ☐ No

Great American Insurance Group, 301 E Fourth Street, Cincinnti, OH 45202. This is not intended as legal advice; if you have any questions or issues of a specific nature, you should consult appropriate legal or regulatory counsel to review the specific circumstances involved. The Great American Insurance Group eagle logo and the word marks Great American® and Great American Insurance Group® are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 1251-ALT-CA (06/20)



GREAT AMERICAN. INSURANCE GROUP

Alternative Markets

State of Nevada
**DEPARTMENT OF BUSINESS & INDUSTRY**
**DIVISION OF INDUSTRIAL RELATIONS**
*Workers' Compensation Section*

# ATTENTION

**Caution**: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

## Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer ... shall provide and secure compensation ... for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer .... if: (a)The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "... every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "... any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

## Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

**Notice of Injury or Occupational Disease (Incident Report Form C-1)** If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

**Claim for Compensation (Form C-4):** If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

**Medical Treatment:** If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

**Temporary Total Disability (TTD):** If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

**Temporary Partial Disability (TPD):** If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

**Permanent Partial Disability (PPD):** When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

**Permanent Total Disability (PTD):** If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

**Vocational Rehabilitation Services:** You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

**Transportation and Per Diem Reimbursement:** You may be eligible for travel expenses and per diem associated with medical treatment.

**Reopening:** You may be able to reopen your claim if your condition worsens after claim closure.

**Appeal Process:** If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

**Nevada Attorney for Injured Workers (NAIW):** If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or
2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

**To File a Complaint with the Division:** If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

**For Assistance with Workers' Compensation Issues:** You may contact the State of Nevada Office for Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1- 888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA , E-mail cha@govcha.nv.gov

*The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:*

Insurer/Administrator:______________________ Contact Person: ______________________

Address:______________________ Telephone Number: ______________________
City State Zip

MCO/Health Care Provider:______________________ Contact Person: ______________________

Address:______________________ Telephone Number: ______________________
City State Zip

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

**Please Type or Print**

# EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

## EMPLOYER

| Employer's Name | Nature of Business (mfg., etc.) | FEIN | OSHA Log # |
|---|---|---|---|
| Office Mail Address | Location . . . If different from mailing address | Telephone | |
| City State Zip | **INSURER** | **THIRD-PARTY ADMINISTRATOR** | |

## EMPLOYEE

| First Name M.I. Last Name | Social Security | Birthdate | Age | Primary Language Spoken |
|---|---|---|---|---|
| Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | | |
| City State Zip | Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No | How long has this person been employed by you in Nevada? | | |
| In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed: | | |
| Telephone | Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No | Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No | | |

## ACCIDENT OR DISEASE

| Date of Injury (if applicable) | Time of injury (Hours; Minute AM/PM) (if applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported |
|---|---|---|---|
| Address or location of accident (Also provide city, county, state) (if applicable) | | | Accident on employer's premises? (if applicable) ☐ Yes ☐ No |
| What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable) | | | |
| How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary. | | | |

## INJURY OR DISEASE

| Specify machine, tool, substance, or object most closely connected with the accident (if applicable) | | Witness | Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No |
|---|---|---|---|
| Part of body injured or affected | If fatal, give date of death | Witness | |
| Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | | Witness | |
| | | Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No |
| If validity of claim is doubted, state reason | | Location of Initial Treatment | |
| Treating physician/chiropractor name | | Emergency Room ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No |

## IMPORTANT LOST TIME INFO

| **IMPORTANT** | How many days per week does employee work? | From ☐ am ☐ pm To ☐ am ☐ pm | Last day wages were earned |
|---|---|---|---|
| Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐ | | Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No | |
| Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost |
| Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired? | Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know | |

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

| Pay period ends on: ☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT | Emloyee is paid: ☐ WEEKLY ☐ BI-WKLY ☐ MONTHLY ☐ SEMI-MONTHLY ☐ OTHER | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo |
|---|---|---|

***For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us***

| ★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law. | Employer's Signature and Title | Date |
|---|---|---|

**Insurer Use Only**

| Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account No. | Class Code |
|---|---|---|---|
| Claims Examiner's Signature | Date | Status Clerk | Date |

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

**Please Type or Print**

# EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

## EMPLOYER

| Employer's Name | Nature of Business (mfg., etc.) | FEIN | OSHA Log # |
|---|---|---|---|
| Office Mail Address | Location . . . If different from mailing address | Telephone | |
| City State Zip | INSURER | THIRD-PARTY ADMINISTRATOR | |

## EMPLOYEE

| First Name M.I. Last Name | Social Security | Birthdate | Age | Primary Language Spoken |
|---|---|---|---|---|
| Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | | |
| City State Zip | Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No | How long has this person been employed by you in Nevada? | | |
| In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed: | | |
| Telephone | Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No | Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No | | |

## ACCIDENT OR DISEASE

| Date of Injury (if applicable) | Time of injury (Hours: Minute AM/PM) (if applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported |
|---|---|---|---|
| Address or location of accident (Also provide city, county, state) (if applicable) | Accident on employer's premises? (if applicable) ☐ Yes ☐ No | | |
| What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable) | | | |
| How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary. | | | |

## INJURY OR DISEASE

| Specify machine, tool, substance, or object most closely connected with the accident (if applicable) | | Witness | Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No |
|---|---|---|---|
| Part of body injured or affected | If fatal, give date of death | Witness | |
| Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | | Witness | |
| | | Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No |
| If validity of claim is doubted, state reason | | Location of Initial Treatment | |
| Treating physician/chiropractor name | | Emergency Room ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No |

## IMPORTANT LOST TIME INFO

| **IMPORTANT** How many days per week does employee work? | From ☐ am ☐ pm To ☐ am ☐ pm | Last day wages were earned |
|---|---|---|
| Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐ | Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No | |

| Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost |
|---|---|---|---|
| Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired? | Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know | |

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

| Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI | Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo |
|---|---|---|

***For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us***

| ★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law. | Employer's Signature and Title | Date |
|---|---|---|

**Insurer Use Only**

| Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account No. | Class Code |
|---|---|---|---|
| Claims Examiner's Signature | Date | Status Clerk | Date |

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Please Type or Print

# EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

## EMPLOYER

Employer's Name | Nature of Business (mfg., etc.) | FEIN | OSHA Log #

Office Mail Address | Location . . . If different from mailing address | Telephone

City State Zip | INSURER | THIRD-PARTY ADMINISTRATOR

## EMPLOYEE

First Name M.I. Last Name | Social Security | Birthdate | Age | Primary Language Spoken

Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City State Zip | Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No | How long has this person been employed by you in Nevada?

In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed:

Telephone | Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No | Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No

## ACCIDENT OR DISEASE

Date of Injury (if applicable) | Time of injury (Hours; Minute AM/PM) (if applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported

Address or location of accident (Also provide city, county, state) (if applicable) | Accident on employer's premises? (if applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

## INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable) | Witness | Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No

Part of body injured or affected | If fatal, give date of death | Witness

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | Witness

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason | Location of Initial Treatment

Treating physician/chiropractor name | Emergency Room ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No

**IMPORTANT** | How many days per week does employee work? | From ☐ am ☐ pm To ☐ am ☐ pm | Last day wages were earned

Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐ | Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

## IMPORTANT LOST TIME INFO

Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired? | Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT | Emloyee is paid: ☐ WEEKLY ☐ BI-WKLY ☐ MONTHLY ☐ SEMI-MONTHLY ☐ OTHER | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

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★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law. | Employer's Signature and Title | Date

### Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

# "NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

## (Incident Report)

## Pursuant to NRS 616C.015

Name of Employer ______________________________________________

| Name of Employee | Social Security Number | Telephone Number |
|---|---|---|
| | | |

| Date of Accident (if applicable) | Time of Accident (if applicable) | Place where accident occurred (if applicable) |
|---|---|---|
| | | |

| What is the nature of the injury or occupational disease? | List any body parts involved: |
|---|---|
| | |

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

| Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO | If yes, when (date and time)? | Has the employee returned to work? ____ YES ____ NO | If yes, when (date and time)? |
|---|---|---|---|

| Was first aid provided? ____ YES ____ NO | If yes, by whom? | Name and address of treating physician, if applicable or known |
|---|---|---|
| Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO | | |

| Was anyone else involved? ____ YES ____ NO | Names of others involved |
|---|---|

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature ____________ Date ____________ Signature of Injured or Disabled Employee ____________ Date ____________

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

***For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us***

Employee should sign, date and retain a copy.
*Original to Employer, Copy to Employee*

C-1 (Rev. 10/05)

# "NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

## (Incident Report)

## Pursuant to NRS 616C.015

Name of Employer ______________________________________________

| Name of Employee | Social Security Number | Telephone Number |
|---|---|---|
| | | |

| Date of Accident (if applicable) | Time of Accident (if applicable) | Place where accident occurred (if applicable) |
|---|---|---|
| | | |

| What is the nature of the injury or occupational disease? | List any body parts involved: |
|---|---|
| | |

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

| Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO | If yes, when (date and time)? | Has the employee returned to work? ____ YES ____ NO | If yes, when (date and time)? |
|---|---|---|---|

| Was first aid provided? ____ YES ____ NO | If yes, by whom? | Name and address of treating physician, if applicable or known |
|---|---|---|
| Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO | | |

| Was anyone else involved? ____ YES ____ NO | Names of others involved |
|---|---|

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

_______________________________________ _______________________________________

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

***For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance <u>Toll Free</u>: 1-888-333-1597 <u>Web site</u>: http://govcha.state.nv.us <u>E-mail</u> cha@govcha.state.nv.us***

Employee should sign, date and <u>retain</u> a copy.

*Original to Employer, Copy to Employee*

# "NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
## (Incident Report)
## Pursuant to NRS 616C.015

Name of Employer ______________________________________________

| Name of Employee | Social Security Number | Telephone Number |
|---|---|---|
| | | |

| Date of Accident (if applicable) | Time of Accident (if applicable) | Place where accident occurred (if applicable) |
|---|---|---|
| | | |

| What is the nature of the injury or occupational disease? | List any body parts involved: |
|---|---|
| | |

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

| Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO | If yes, when (date and time)? | Has the employee returned to work? ____ YES ____ NO | If yes, when (date and time)? |
|---|---|---|---|
| Was first aid provided? ____ YES ____ NO | If yes, by whom? | Name and address of treating physician, if applicable or known | |
| Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO | | | |

| Was anyone else involved? ____ YES ____ NO | Names of others involved |
|---|---|
| | |

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

______________________________________ ______________________________________
Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

***For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us***

Employee should sign, date and retain a copy.
*Original to Employer, Copy to Employee*

## EMPLOYER'S WAGE VERIFICATION FORM
**(Pursuant to NRS 616C.045(2)(d))**

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

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### EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: __________________ Injured Employee's Name (Last/First/M.I.): ________________________ Social Security # ______________________

Claim No.: ___________________________________ Date of Injury: ______________________________ Date of Hire: ___________________________

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: ________________ # of days per week: ________________

On the date of injury, the employee's wage was: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: ________________

Was vacation paid during the applicable twelve week period?_____________ If so, during what pay period? ____________________________________

Was sick leave paid during the applicable twelve week period? ____________ Was the injured employee paid for any holidays during the applicable twelve week period? ________ Did employee receive payment for overtime during the applicable twelve week period? ___________ Did employee receive termination pay during the applicable twelve week period? ________

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: ______________________ Explain: ______________________________________________________________________

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned __________ to __________.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ _______________

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned _________ to _________.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ ______________________

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?_____________ Monetary value of meals $__________________per [ ] Day [ ] Week [ ] Month

Lodging $___________________per [ ] Day [ ] Week [ ] Month

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**TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS**. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _______ through ______. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

**If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.**

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

| Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips | Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips |
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| Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason |
|---|---|---|---|---|---|---|---|---|
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Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday
Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other
Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other
Explain "other":
Date the employee last worked AFTER injury occurred: _______________ Date returned to work: _________________

This information is true and correct as taken from the employee's payroll records.

Print Name: ________________________________ Signature: ____________________________________________

Date: ____________________________________ Employer: ____________________________________________

Insurer: __________________________________ Third-Party Administrator: ______________________________

## EMPLOYER'S WAGE VERIFICATION FORM
## (Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

### EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: ____________ Injured Employee's Name (Last/First/M.I.): ____________ Social Security # ____________

Claim No.: ____________ Date of Injury: ____________ Date of Hire: ____________

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: ____________ # of days per week: ____________

On the date of injury, the employee's wage was: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: ____________

Was vacation paid during the applicable twelve week period?____________ If so, during what pay period? ____________

Was sick leave paid during the applicable twelve week period? ____________ Was the injured employee paid for any holidays during the applicable twelve week period? ________ Did employee receive payment for overtime during the applicable twelve week period? ____________ Did employee receive termination pay during the applicable twelve week period? ________

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: ____________ Explain: ____________

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned __________ to __________.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ ____________

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned ________ to ________.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ ____________

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?____________ Monetary value of meals $____________per [ ] Day [ ] Week [ ] Month

Lodging $____________per [ ] Day [ ] Week [ ] Month

**TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS**. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _______ through ______. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

**If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.**

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

| Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips | Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips |
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| Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason |
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Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday
Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other
Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other
Explain "other":
Date the employee last worked AFTER injury occurred: ____________ Date returned to work: ____________

This information is true and correct as taken from the employee's payroll records.

Print Name: ____________ Signature: ____________

Date: ____________ Employer: ____________

Insurer: ____________ Third-Party Administrator: ____________

# EMPLOYER'S WAGE VERIFICATION FORM
## (Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

---

## EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: ________________ Injured Employee's Name (Last/First/M.I.): ______________________ Social Security # ______________________

Claim No.: ________________________________ Date of Injury: ____________________________ Date of Hire: ____________________________

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: _______________ # of days per week: _______________

On the date of injury, the employee's wage was: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: ______________

Was vacation paid during the applicable twelve week period?____________ If so, during what pay period? ______________________

Was sick leave paid during the applicable twelve week period? ____________ Was the injured employee paid for any holidays during the applicable twelve week period? ________ Did employee receive payment for overtime during the applicable twelve week period? ___________ Did employee receive termination pay during the applicable twelve week period? ________

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: ____________________ Explain: ______________________________________________

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned _________ to _________.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ _______________

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned _________ to _________.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ __________________

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?____________ Monetary value of meals $________________per [ ] Day [ ] Week [ ] Month

Lodging $__________________per [ ] Day [ ] Week [ ] Month

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**TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS**. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _______ through ______. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

**If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.**

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

| Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips | Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Declared Tips |
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| Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason | Dates of Absence Begin | Dates of Absence End | Reason |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other

Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other

Explain "other":

Date the employee last worked AFTER injury occurred: ______________ Date returned to work: ________________

This information is true and correct as taken from the employee's payroll records.

Print Name: ______________________________ Signature: ______________________________

Date: ______________________________ Employer: ______________________________

Insurer: ______________________________ Third-Party Administrator: ______________________________

# APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

| Name (Last, First, Middle Initial) | | | Claim Number |
|---|---|---|---|
| Present Address (P.O. Box, Apt. No., Street) | | | Social Security Number |
| City | State | Zip | Date of Injury |
| Residence at time of injury: | | | (For Insurer's Use Only)<br>[__] Approved ____________<br>[__] Disapproved Initials & Date |

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

| Date | Beginning Point of Travel Address | Destination Name/Address | Enter Travel Time | Leave Travel Time | Daily Expense Reimbursement | | | | Miles One Way | Mileage Allowed (For Insurers Use Only) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Meals | | | Lodging | | |
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| | | | | | | | | **TOTAL MILES:** | | |
| **Total of ____________ Miles X 2 @ $ _______ . ____ per Mile =** | | | | | | | | | | |

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

_______________________________ _______________________________

Injured Employee's Signature Date

## Reimbursement for Costs of Transportation and Meals

**Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.**

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

**NAC 616C.153 Reimbursement for air fare.** With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

**NAC 616C.156 Limitations on reimbursements.**

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

**Notice**

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

# APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

| Name (Last, First, Middle Initial) | | | Claim Number |
|---|---|---|---|
| Present Address (P.O. Box, Apt. No., Street) | | | Social Security Number |
| City | State | Zip | Date of Injury |
| Residence at time of injury: | | | (For Insurer's Use Only)<br>[__] Approved ________<br>[__] Disapproved Initials & Date |

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

| Date | Beginning Point of Travel Address | Destination Name/Address | Enter Travel Time | Leave Travel Time | Daily Expense Reimbursement | | | | Miles One Way | Mileage Allowed (For Insurers Use Only) |
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| | | | | | | | | **TOTAL MILES:** | | |
| | | | | | | | | | **Total of ____________ Miles X 2 @ $ ________ . ____ per Mile =** | |

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

_______________________________ Injured Employee's Signature

_______________________________ Date

## Reimbursement for Costs of Transportation and Meals

**Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.**

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

**NAC 616C.153 Reimbursement for air fare.** With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

**NAC 616C.156 Limitations on reimbursements.**

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

**Notice**

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

# APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

| Name (Last, First, Middle Initial) | | | Claim Number |
|---|---|---|---|
| Present Address (P.O. Box, Apt. No., Street) | | | Social Security Number |
| City | State | Zip | Date of Injury |
| Residence at time of injury: | | | (For Insurer's Use Only)<br>[__] Approved ________<br>[__] Disapproved Initials & Date |

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

| Date | Beginning Point of Travel Address | Destination Name/Address | Enter Travel Time | Leave Travel Time | Daily Expense Reimbursement | | | | Miles One Way | Mileage Allowed (For Insurers Use Only) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Meals | | | Lodging | | |
| | | | | | B | L | D | | | |
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| | | | | | | | | **TOTAL MILES:** | | |
| | | | | **Total of ____________ Miles X 2 @ $ ________ . ____ per Mile =** | | | | | | |

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

______________________________ Injured Employee's Signature

______________________________ Date

## Reimbursement for Costs of Transportation and Meals

**Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.**

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

**NAC 616C.153 Reimbursement for air fare.** With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

**NAC 616C.156 Limitations on reimbursements.**

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

**Notice**

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

# EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: ______________________________

EMPLOYEE: ______________________________

EMPLOYEE IDENTIFICATION NUMBER: ______________________________

DEPARTMENT: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

PAY PERIOD: ______________ TO ______________

AMOUNT OF TIPS RECEIVED DURING PERIOD: $______________

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

______________________________ ______________

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

# EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: ______________________________

EMPLOYEE: ______________________________

EMPLOYEE IDENTIFICATION NUMBER: ______________________________

DEPARTMENT: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

PAY PERIOD: ____________________ TO ____________________

AMOUNT OF TIPS RECEIVED DURING PERIOD: $______________________________

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

______________________________ ____________________

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

# EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: ______________________________

EMPLOYEE: ______________________________

EMPLOYEE IDENTIFICATION NUMBER: ______________________________

DEPARTMENT: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

PAY PERIOD: ______________ TO ______________

AMOUNT OF TIPS RECEIVED DURING PERIOD: $______________

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

______________________________ ______________

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

# NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

State of Nevada
Department of Business and Industry
Division of Industrial Relations

# OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – **PART 1**
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – **PARTS 1 & 2**

| **Submitted By:** | ☐ Insurer ☐ TPA |
|---|---|
| Company: | |
| Submitter Name: | |
| Telephone: | |
| Email: | |

**PART 1 (Claim Information)**

| | |
|---|---|
| Insurer Name: | |
| Insurer FEIN: | |
| Insurer Certificate Number: | |
| Claimant's Employer: | |
| Claimant's Name: | First: Last: |
| Claim Number: | |
| Claim Disposition: | ☐ Accepted ☐ Denied |
| Reason for Denial: | ☐ 1-Pending medical investigation ☐ 2-Negative test/no exposure ☐ 3-Not in course/scope ☐ 4-Not compensable/no disease ☐ 5-Late reporting ☐ 6-Failure to correct predisposing condition ☐ 7-Misc (duplicate claim, wrong insurer/uninsured, etc) |

**CLAIMANT (Choose one) & CLAIM ACCEPTED/DENIED PURSUANT TO NRS (Choose one):**

☐ **FIREFIGHTER**
- ☐ NRS 617.453 CANCER
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

☐ **POLICE OFFICER** (PEACE OFFICERS PER NRS 289.010 INCLUDED)
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS
- ☐ NRS 617.487 HEPATITIS

☐ **ARSON INVESTIGATOR**
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES

☐ **EMERGENCY MEDICAL ATTENDANT**
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

| | | |
|---|---|---|
| Date of Injury: | | |
| Date Claim (C4) Received by Insurer/TPA: | | |
| Date Accepted/Denied: | | |
| Estimated Medical Costs of Claim: | $ | Diagnosis Confirmed: ☐ Yes ☐ No |
| Description of Claim: | | |
| Initial Claim Closure Date: | Date Claim Reopened (if applicable): | Subsequent Claim Closure Date (if applicable): |

**PART 2 (Appeal Information)**

| **INITIAL APPEAL OF:** ☐ CLAIM DENIAL ☐ CLAIM ACCEPTANCE | **SUBSEQUENT APPEAL OF DECISION BY:** ☐ HO ☐ AO ☐ DC |
|---|---|
| Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer | Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer |
| Appeal Number: | Appeal Number: |
| Date Appeal Filed: | Date Appeal Filed: |
| Hearing Date: | Hearing Date: |
| Decision Date: | Decision Date: |
| Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain): | Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain): |
| Decision By: ☐ Hearing Officer ☐ Appeals Officer | Decision By: ☐ Appeals Officer ☐ District Court ☐ Supreme Court |

State of Nevada
Department of Business and Industry
Division of Industrial Relations

# OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – **PART 1**
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – **PARTS 1 & 2**

| **Submitted By:** | ☐ Insurer ☐ TPA |
|---|---|
| Company: | |
| Submitter Name: | |
| Telephone: | |
| Email: | |

**PART 1 (Claim Information)**

| | |
|---|---|
| Insurer Name: | |
| Insurer FEIN: | |
| Insurer Certificate Number: | |
| Claimant's Employer: | |
| Claimant's Name: | First: Last: |
| Claim Number: | |
| Claim Disposition: | ☐ Accepted ☐ Denied |
| Reason for Denial: | ☐ 1-Pending medical investigation ☐ 2-Negative test/no exposure ☐ 3-Not in course/scope ☐ 4-Not compensable/no disease ☐ 5-Late reporting ☐ 6-Failure to correct predisposing condition ☐ 7-Misc (duplicate claim, wrong insurer/uninsured, etc) |

**CLAIMANT (Choose one) & CLAIM ACCEPTED/DENIED PURSUANT TO NRS (Choose one):**

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- ☐ NRS 617.453 CANCER
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- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES

☐ **EMERGENCY MEDICAL ATTENDANT**
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

| | | |
|---|---|---|
| Date of Injury: | | |
| Date Claim (C4) Received by Insurer/TPA: | | |
| Date Accepted/Denied: | | |
| Estimated Medical Costs of Claim: | $ | Diagnosis Confirmed: ☐ Yes ☐ No |
| Description of Claim: | | |
| Initial Claim Closure Date: | Date Claim Reopened (if applicable): | Subsequent Claim Closure Date (if applicable): |

**PART 2 (Appeal Information)**

| **INITIAL APPEAL OF:** ☐ CLAIM DENIAL ☐ CLAIM ACCEPTANCE | **SUBSEQUENT APPEAL OF DECISION BY:** ☐ **HO** ☐ **AO** ☐ **DC** |
|---|---|
| Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer | Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer |
| Appeal Number: | Appeal Number: |
| Date Appeal Filed: | Date Appeal Filed: |
| Hearing Date: | Hearing Date: |
| Decision Date: | Decision Date: |
| Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain): | Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain): |
| Decision By: ☐ Hearing Officer ☐ Appeals Officer | Decision By: ☐ Appeals Officer ☐ District Court ☐ Supreme Court |

State of Nevada
Department of Business and Industry
Division of Industrial Relations

# OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – **PART 1**
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – **PARTS 1 & 2**

| **Submitted By:** | ☐ Insurer ☐ TPA |
|---|---|
| Company: | |
| Submitter Name: | |
| Telephone: | |
| Email: | |

**PART 1 (Claim Information)**

| | |
|---|---|
| Insurer Name: | |
| Insurer FEIN: | |
| Insurer Certificate Number: | |
| Claimant's Employer: | |
| Claimant's Name: | First: Last: |
| Claim Number: | |
| Claim Disposition: | ☐ Accepted ☐ Denied |
| Reason for Denial: | ☐ 1-Pending medical investigation ☐ 2-Negative test/no exposure ☐ 3-Not in course/scope<br>☐ 4-Not compensable/no disease ☐ 5-Late reporting ☐ 6-Failure to correct predisposing condition<br>☐ 7-Misc (duplicate claim, wrong insurer/uninsured, etc) |

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- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

| | | |
|---|---|---|
| Date of Injury: | | |
| Date Claim (C4) Received by Insurer/TPA: | | |
| Date Accepted/Denied: | | |
| Estimated Medical Costs of Claim: | $ | Diagnosis Confirmed: ☐ Yes ☐ No |
| Description of Claim: | | |
| Initial Claim Closure Date: | Date Claim Reopened (if applicable): | Subsequent Claim Closure Date (if applicable): |

**PART 2 (Appeal Information)**

| **INITIAL APPEAL OF:**<br>☐ **CLAIM DENIAL** ☐ **CLAIM ACCEPTANCE** | **SUBSEQUENT APPEAL OF DECISION BY:**<br>☐ **HO** ☐ **AO** ☐ **DC** |
|---|---|
| Appealed By: ☐ Claimant/Dependent/Representative<br>☐ Employer/Insurer | Appealed By: ☐ Claimant/Dependent/Representative<br>☐ Employer/Insurer |
| Appeal Number: | Appeal Number: |
| Date Appeal Filed: | Date Appeal Filed: |
| Hearing Date: | Hearing Date: |
| Decision Date: | Decision Date: |
| Decision: ☐ Affirmed ☐ Reversed ☐ Remanded<br>☐ Modified ☐ Dismissed ☐ Stip (Explain): | Decision: ☐ Affirmed ☐ Reversed ☐ Remanded<br>☐ Modified ☐ Dismissed ☐ Stip (Explain): |
| Decision By:<br>☐ Hearing Officer ☐ Appeals Officer | Decision By:<br>☐ Appeals Officer ☐ District Court ☐ Supreme Court |