Nevada Claim Forms

- Form C-1 FROI
- Form C-3 Employer's Report of Injury
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- Form D-26 Travel Reimbursement
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*FirstComp, a Division of Markel Service, Incorporated is a servicing entity for Markel Insurance Company, Markel American Insurance Company, Deerfield Insurance Company and FirstComp Insurance Company.

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State of Nevada
Department of Business & Industry
Division of Industrial Relations
Workers' Compensation Section

ALTERNATIVE CHOICE OF PHYSICIAN or CHIROPRACTOR (NRS 616C.090)

A list of the Panel of Treating Physicians or Chiropractors, or those health care providers, with whom your insurer has contracted, can be obtained from your insurer or third-party administrator upon written request. Your insurer or third-party administrator has 3 working days to provide you the list pursuant to NAC 616C.030.

If within the **first 90 days after the date of injury**, you are not satisfied with the **first** treating physician or chiropractor and

> Your insurer **has entered** into a contract with a managed care organization or with health care providers; you must select an alternative physician or chiropractor according to the terms of the contract. This selection may be made without the prior approval of the insurer. If after choosing your physician or chiropractor, you move to a county not serviced by the contracted managed care organization or health care providers and the insurer deems it impractical for you to continue treating with the physician or chiropractor, you must choose a treating physician or chiropractor who has agreed to the to the terms of the contract unless the insurer authorizes you to choose another physician or chiropractor;

or

> Your insurer **has not entered** into a contract with an organization for managed care, or with health care providers, you may select an alternative physician or chiropractor from the Panel of Treating Physicians and Chiropractors.

NOTICE: Any further changes in your treating physician or chiropractor must be in writing and approved by the insurer. If, at any time, you are dissatisfied with a physician or chiropractor selected by yourself, the insurer, managed care organization, or health care provider, a change may be made by submitting a written request to the insurer indicating the name of the alternate physician or chiropractor. The insurer shall approve or deny this request within ten (10) days after receipt of the written request or it shall be deemed approved. You will receive written notification if the insurer denies this request which will include the reason for the denial and appeal rights.

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

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: __________________________________

REQUEST FOR REIMBURSEMENT OF EXPENSES FOR TRAVEL AND LOST WAGES

Pursuant to NRS 616C.365 and 616C.477

Claim No: ______________________

Date of Injury: ______________________

Insurer's Name: ______________________

Injured Employee's Name: ______________ Social Security No. ______________

Present Employer: ______________ Phone No: ______________

Date of Hearing/Treatment: ______________________

Time of Hearing/Treatment: Begin ______________ End ______________

From: Place of Employment ☐ Residence* ☐ (Check One) *DO NOT USE RESIDENCE FOR EXTENDED TRAVEL BENEFIT

Address: ______________________

To: Place of Hearing/Treatment: ______________________

Address: ______________________

FOR TRAVEL AND LOST WAGES FOR HEARINGS Pursuant to NRS 616C.365

		FOR INSURER'S USE
Total Miles Traveled (One Way)	______________	Miles X 2 X
		per mile =
Food	______________	
Lodging	______________	
Lost Wages	______________	
Total Expenses	______________	Total $

LOST WAGES COMPENSATION FOR EXTENDED MEDICAL TRAVEL
Pursuant to NRS 616C.477

		FOR INSURER'S USE
Employer at time of injury:	______________	Qualify? ☐ YES or ☐ NO
Total Miles Traveled (One Way)	______________	TTD ☐ 50% or ☐ 100 %
Total Time Absent from Employment	______________	TTD RATE $

I declare under penalty of perjury that the above amounts were necessarily incurred and that they are true and correct to the best of my knowledge.

______________________ ______________________

Date Signature of Injured Employee

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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 required 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. 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 the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

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.

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

"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 Website: 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

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) [__] Approved ______________ [__] 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			
								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

Claim Number ______________

INJURED EMPLOYEE'S REQUEST FOR COMPENSATION
(Pursuant to NRS 616C.475(6))

ANSWER ALL QUESTIONS, DATE, SIGN AND RETURN TO YOUR CLAIMS AGENT

1. Name: ______________________________ Social Security # ____________________ Phone No: ______________________
2. Physical address: ____
   Street City State Zip
   Mailing address: ____
   Street/P.O.Box City State Zip
   Is this a change of address? [ ] Yes [ ] No
3. Employer at time of injury: ____
4. Supervisor's name: ____
5. Name of your attending physician or chiropractor: ____
6. Date on which you were last examined by attending physician or chiropractor: ______________________________
7. Date of next appointment with physician or chiropractor: ______________________________
8. a. Have you been released to return to work by your attending physician or chiropractor? [ ] Yes [ ] No
   b. If so, give the date of release: ______________________________
9. a. Have you returned to work with another employer? [ ] Yes [ ] No
   b. Are you receiving payment from any employer? [ ] Yes [ ] No
   c. Date on which you returned to work: ____
   d. Name of employer for whom you returned to work: ____
   e. Address: ____
10. Have you been disabled and unable to work in <u>any</u> <u>occupation</u> for at least 5 consecutive days, or 5 cumulative days within a 20 day period? [ ] Yes [ ] No
11. Date on which you last worked: __________________ For Whom: ______________________________
12. When do you expect to be able to return to your regular occupation? ______________________________
13. Would you be able to work at a light duty type job now? [ ] Yes [ ] No
    Comment: ____
    ____
    ____
14. Has your employer offered you a light duty type job? [ ] Yes [ ] No
    a. If yes, when was the light duty job offered? ________________________

Per NRS 616D.300, I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits. Further, I understand falsification may subject me to civil and criminal penalties. I certify the above information is correct to the best of my knowledge.

______________________________ ______________________________
Date Signature

____
CITY COUNTY STATE

NOTE: An explanation of the methods used to calculate your average monthly wage and compensation benefits should accompany your first compensation check. If you did not receive this, please contact your claims agent.

FOR CLAIMS AGENT'S USE ONLY

PAY: From ________________ To ___________________ Rev. date ____________
From ________________ To ___________________ TT Final TT TP

______________________________ ______________________________
Date Signature