PTD CLAIM - AMW/MONTHLY RATE VERIFICATION FORM

(FOR CLAIMS WITH DOI OR DATE OF DISABLEMENT BEFORE 1/1/2004)

INSURER INFORMATION:	
Insurer Name:	
Nevada Certificate of Authority No.:	
NCCI Carrier Code (Private Carriers):	
Federal Employer Identification Number (FEIN):	

INJURED EMPLOYEE	
Injured Employee Last Name:	
Injured Employee First Name:	
Injured Employee SSN:	

CLAIM INFORMATION	
Date of Injury or Occ Disease Disablement:	
Claim Number:	
TPA (if applicable):	
Employer:	

CALCULATIONS	
Average Monthly Wage (AMW):	
Monthly PTD Rate (prior to offset):	
Date of 1st PTD Payment:	
Date of Last PTD Payment:	

SUPPORTING INFORMATION INCLUDED ('X' all that apply)	
D-5 (Wage Calculation Form)	
D-8 (Wage Verification Form)	
AMW Determination	
PTD Determination	
Decisions/Orders	
Other (Specify)	

OTHER INFO		
Annuity Purchased?		YES OR NO (Y OR N)
Offset (PPD, Subro, Etc) Applied?		YES OR NO (Y OR N)

SUBMITTED BY:		
Place an "X" in one box	TPA :	
	Insurer:	
	Other:	
	Name:	
	Title:	
	Company:	
	Email:	
	Phone:	
	Date:	