

INSURER'S SUBSEQUENT INJURY CHECKLIST

Notice to Insurer: This form must be completed and provided with all supporting documentation for claims submitted for reimbursement from the Subsequent Injury Account.

PART ONE

INJURED EMPLOYEE _____ DATE OF INJURY _____
 CLAIM NUMBER _____ INSURER _____
 THIRD-PARTY ADMINISTRATOR _____ EMPLOYER _____
 SUBMITTED BY _____ ASSOCIATION ADMINISTRATOR _____
 INITIAL REQUEST _____ SUPPLEMENTAL REQUEST _____

Please check and complete applicable blanks. All supporting documentation must be submitted in chronological order, oldest information on top. This information must be bound in a file folder and sectioned according to this form.

Check one: Private Insurer Self-insured Employer Self-insured Association

PART TWO

_____ Letter of application to the Subsequent Injury Account specifying the statute pertinent to this application.

PART THREE

a. _____ Medical documentation specifically showing that compensation for disability is substantially greater due to the combined effects of the preexisting impairment than that which would have resulted from the subsequent injury alone.

Doctor(s) providing medical documentation. _____

_____ Medical documentation of the preexisting permanent physical impairment of 6% or greater, including prior PPD evaluation, if available.

Percentage	_____	Body Part	_____
Percentage	_____	Body Part	_____
Percentage	_____	Body Part	_____

_____ Verification of the employer's knowledge of impairment at the time of hire or retention in employment after obtaining knowledge of impairment.

Date of hire _____
 Date of employer's knowledge of impairment _____
 Date of retention in employment _____

_____ Notification of a possible claim against the Subsequent Injury Account, submitted within 100 weeks of the date of injury.

Time lag _____ weeks.

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VERIFICATION**

NRS 616B.557, 616B.578
OR 616B.587

Lagtime _____ weeks.

PART THREE (continued)

b. _____ Verification of false representation at the time of hire

_____ Date insurer became aware of the false representation. _____

_____ Notification of a possible claim against the Subsequent Injury Account submitted within 60 days of the date of the subsequent injury, or date the insurer learned of the false representation

_____ Time lag _____ days.

PART FOUR

Supporting Documentation

_____ Employer's Report of Injury (Form C-3)

_____ Employee's Claim for Compensation/Initial Report of Treatment (Form C-4)

_____ False representation (NRS 616B.560, 616B.581 or 616B.590 only)

PART FIVE

_____ Medical reporting regarding subsequent injury claim

_____ Medical documentation regarding preexisting impairment

_____ Permanent partial disability evaluation and calculation, subsequent injury claim

PART SIX

_____ Wage verification and calculation

_____ Total expenditure documentation: Please provide calculator tapes for expenses requested. Printouts, log sheets, checks, etc., must be matched to the bill, explanation of benefits and/or rationale for payment in chronological order, oldest information on top.

_____ Computer printout(s) _____ Payment log sheet(s) _____

_____ Copies of check(s) _____ Copies of medical bills _____

_____ Explanation of benefits (EOB) _____

_____ Travel reimbursement, which must include copies of receipts and/or orders or requests for payments which specify the method of transportation; destination; mileage allowed; date(s) of travel; and per diem and/or lodging allowed. If any payment is made other than that shown, justification must be given.

_____ Other (specify) _____

PART SEVEN

Other Pertinent Documentation

_____ Insurer determinations and all documents from HO, AO, or District Court

_____ All vocational rehabilitation information

_____ Subrogation information

_____ Permanent Total information

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Lagtime _____ days.

PART EIGHT

TOTAL EXPENDITURES OF CLAIM

MEDICAL

Medical Treatment: _____

Travel associated with medical care: _____

Other (Specify) _____

Total Medical: _____

COMPENSATION

Temporary Total Disability: _____

Temporary Partial Disability: _____

Permanent Partial Disability: _____

Other (Specify) _____

Total Compensation: _____

VOCATIONAL REHABILITATION

Maintenance: _____

Schooling and/or Supplies: _____

Counselor Services: _____

Travel: _____

Other (Specify) _____

Total Rehabilitation: _____

Other (Specify)

Total Other: _____

GRAND TOTAL EXPENDITURES: _____

No administrative costs will be considered part of the claim pursuant to NAC 616B.707(2). These include, but are not limited to, utilization review services, attorney fees, cost of medical analysis or ratings conducted for the purpose of establishing a subsequent injury account, and any other administrative costs.