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.

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
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.