Index of Claims System – Claim Registration

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

Claim Number: | Claim Type: Choose... | ○ Create ○ Update

SUBMITTER INFORMATION

Date Submitted to WCS: | First Name: | Last Name:

Submitter Phone Number: | Email:

INJURED EMPLOYEE INFORMATION

First Name: | MI: | Last Name: | ○ Male ○ Female

DOB: | Zip Code: | Undocumented ☐ | SSN:

CLAIM INFORMATION

Date of Injury/Disablement: | C4 Received by Insurer/TPA: | Accepted/Denied:

Accepted: | Type of Loss: Choose... | Catastrophic:

Nature of Injury: Choose... | Cause of Injury: Choose...

Permanent Impairment %:

	Benefit Type	Benefit Start	Benefit End
Death Date:	Choose...		
Death Result of Injury:	Choose...		

EMPLOYER

Employer Name: | Employer FEIN: | Phone:

Address: | City: | State: | Zip:

INSURER

Insurer Name: | Insurer FEIN:

TPA Name:

CLAIM CLOSED/REOPENED

Date Claim Closed: | NRS Close Code: Choose... | Total Cost at Closure:

Reopen Effective Date: | Reopen Request Date:

Reopen Decision Date: | Reopen Decision:

PRIVATE CARRIER INFORMATION

Policy Effective Date: | Policy Expiration Date: | Policy Number:

INJURY INFORMATION

Body Part Code	Injury Side	Accepted	Rated
Choose...			
Choose...			
Choose...			
Choose...			

☐ Include Claim History Report

Handwritten Forms will not be accepted.

I hearby certify that the information contained on this form is true and correct. I also certify that I am a duly authorized representative of the Submitter *

Enter Your Name to Sign | Enter the Date