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

Index of Claims System Claim Registration

Claim Number: Claim Type: ○ Medical Only ◉ Lost Time

SUBMITTER INFORMATION

Date Claim Submitted to WCS:	Submitter First Name:	Submitter Last Name:

Phone: Email:

INJURED EMPLOYEE INFORMATION

First Name: M.I. Last Name:

Date of Birth: Gender: ◉ Male ◉ Female Zip Code:

Undocumented Injured Employee: ○ Yes ○ No Injured Employee SSN:

CLAIM INFORMATION

Date of Injury or Disablement:	Date C-4 Received by Insurer/TPA:	Date Claim was Accepted/Denied:

Accepted: ○ Yes ○ No Type of Loss: Catastrophic: ○ Yes ○ No

Nature of Injury Code: 01-No Physical Injury-i.e., Glasses, (Cause of Injury Code: 03-Temperature Extremes-Burn or Scald – He

Permanent Impairment Percentage: %

Death Date: Death Result of Injury: ○ Yes ○ No ○ Unknown

Benefit Type:	Benefit Period Start Date:	Benefit Period End Date:

EMPLOYER

Employer Name: Employer FEIN: Phone:

Address: City: State: Postal Code:

INSURER

Insurer Name: Insurer FEIN:

TPA: Insurer Type:

CLAIM CLOSED/REOPENED

Date Closed:	NRS Close Code: ☐ NRS 616C.235 (1) ☐ NRS 616C.235 (2)	Total Cost at Closure: $

Reopen Effective Date: Reopen Request Date:

Reopen Decision Date: Reopen Decision: ○ Yes ○ No

PRIVATE CARRIER INFORMATION

Policy Effective Date: Policy Expiration Date: Policy Number:

INJURY INFORMATION

Body Part Code: 0000 Description: 0000

Injury Side: ◉ Left ◉ Right ◉ Both ☐ Accepted ☐ Rated

Body Part Code: 0000 Description: 0000

Injury Side: ◉ Left ◉ Right ◉ Both ☐ Accepted ☐ Rated

Body Part Code: 0000 Description: 0000

Injury Side: ◉ Left ◉ Right ◉ Both ☐ Accepted ☐ Rated

◉ Create or ◉ Update ☐ Include Claim History Report

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

Sign Date

Handwritten Forms will not be accepted.