



Division of Industrial Relations
WORKERS' COMPENSATION SECTION

**C-4 Form Healthcare Provider
Responsibilities and Coverage
Verification Service**



Workers' Compensation Section
US Bank Building, Ste 300, 2300 W Sahara Ave,
Las Vegas, NV 89102

Workers' Compensation Section **MISSION STATEMENT**

Impartially serve the interests of Nevada employers and employees by providing assistance, information, and a fair and consistent regulatory structure focused on:

- Ensuring the timely and accurate delivery of workers' compensation benefits
- Ensuring employer compliance with the mandatory coverage provisions



Please submit questions in the chat box, and the Workers' Compensation Section (WCS) will answer them there.

You can also email your questions to:

WCSHelp@dir.nv.gov

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4 PLEASE TYPE OR PRINT					
EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED					
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)
Mailing Address			Age	Height	Weight
City	State	Zip	Telephone		
Email Address				Primary Language Spoken	
INSURER	THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred		
Employer's Name/Company Name				Telephone	
Office Mail Address (Number and Street)					
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported	
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?				Witnesses to the Accident (if applicable)	
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected		
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 516A TO 516D, INCLUSIVE, OR CHAPTER 517 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>					
Date	Place	Employee's Original or Electronic Signature			
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT					
Place Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease		Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)		
Hour					
Treatment:			Have you advised the patient to remain off work five days or more? <input checked="" type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty		
X-Ray Findings:			If modified duty, specify any limitations/restrictions: _____		
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)					
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:		
Address			INSURER'S USE ONLY		
City	State	Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN)		
			Choose (if applicable) _____		

What is the C-4 Form?

C-4

Employee's Claim for Compensation/ Report of Initial Treatment

C-4 FORM

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT

EMPLOYEE INFORMATION

First Name: _____ Last Name: _____ Birthdate: _____ Sex: _____ Height: _____ Weight: _____ Social Security Number: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

EMPLOYER INFORMATION

Employer Name: _____ Employer Address: _____ City: _____ State: _____ Zip: _____
Employer Phone Number: _____

INJURY INFORMATION

Date of Injury: _____ Time of Injury: _____
Location of Injury: _____
Description of Injury: _____

HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

ADDITIONAL INFORMATION

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary.)
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?
Name of work or occupational disease: _____

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Date: _____
Signature of Health Care Provider: _____
Signature of Employee: _____




Provided by
Healthcare Providers
(HCP) to Injured
Employees when they
Seek Initial Treatment

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED

First Name John	M.I. Lloyd	Last Name Cruz	Birthdate 01/30/1972	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)
Mailing Address 7512 Java Sparrow St.		Age	Height	Weight	Social Security Number 680-xx-xxx
City North Las Vegas		State Nevada	Zip 89084	Telephone	
Email Address Jlloyd_cruz@gmail.com				Primary Language Spoken	
INSURER		THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred	
Employer's Name/Company Name Viva Marketing				Telephone	
Office Mail Address (Number and Street) 7918 Bruce Street.					
Date of Injury (if applicable) 07/09/24	Hours Injury (if applicable) 7:18 am	Date Employer Notified 07/09/24	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported Bea Alonzo	
Address or Location of Accident (if applicable) 7918 Bruce Street.					
What were you doing at the time of the accident? (if applicable) Walking down the hallway					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)				Witnesses to the Accident (if applicable)	
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					
<p>If a worker gets injured</p> 					
<p><small>I CERTIFY THAT THE INDUSTRIAL PRACTITIONER, COMPANY, OR INJURY OR DISEASE SUBSTANCE</small></p> <p>Date</p> <p>Place</p> <p>Date</p> <p>Hour</p> <p>Treatment</p> <p>X-Ray Findings</p> <p>From information you directly received <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is additional information available? Do you know of any other information available?</p> <p>Date</p>					
Address				INSURER'S USE ONLY	
City	State	Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN)		
			Choose (if applicable)		

The Injured Employee has

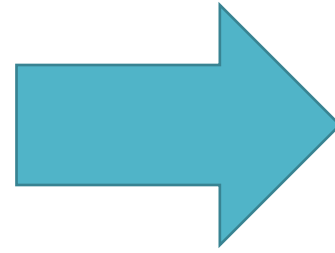
90

DAYS

From the date of injury

to seek medical treatment.

NRS 616C.040
C-4 Submission
by HCP
3 Working Days



NRS 616C.065
Insurer/TPA
Approve or Deny Claim
30 Days



EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED		INSURER'S CLAIM NUMBER (insert on only)
First Name	Last Name	First Initial
Mailing Address		City
State	Zip	Telephone
City		State
Telephone		Primary Language Spoken
INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (job title) What injury or occupational disease occurred?
Employer's Name/Company Name		Telephone
Office Mail Address (Number and Street)		
Date of Injury (if available)	Hours (if available)	Date Employer Notified
Address or Location of Accident (if applicable)		Last Day of Work After Injury or Occupational Disease
Supervisor to Whom Injury Reported		
What were you doing at the time of the accident? (if applicable)		
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)		
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?		Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease		Part(s) of Body Injured or Affected
<small>LETTER THAT THIS REPORT IS THE PROPERTY OF THE INSURER AND NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE INSURER. THE INSURER'S LIABILITY IS LIMITED TO THE AMOUNT OF THE POLICY. THE INSURER'S LIABILITY IS NOT GUARANTEED. THE INSURER'S LIABILITY IS LIMITED TO THE AMOUNT OF THE POLICY. THE INSURER'S LIABILITY IS NOT GUARANTEED. THE INSURER'S LIABILITY IS LIMITED TO THE AMOUNT OF THE POLICY. THE INSURER'S LIABILITY IS NOT GUARANTEED.</small>		
Date		
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT		
Place	Name of Facility	
Date	Onset and Duration of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or other controlled substances at the time of the accident?
Hour		<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)
Treatment		How long did the patient remain off work (if any)?
X-Ray Findings		<input type="checkbox"/> No <input type="checkbox"/> Yes (include date, time, to, and by whom)
From information given by the employee, together with medical evidence, can you clearly connect this injury or occupational disease as job related?		<input type="checkbox"/> Not Job Related <input type="checkbox"/> Job Related
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)		
Date	Print Health Care Provider's Name	Verify that the employer's copy of this form was returned to the employer on:
Address		INSURER'S USE ONLY
City	State	Zip
Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature	Degree (MD, DO, DC, PA-C, APRN, etc.)	
Print Name		

PROVIDER - TREATING HEALTHCARE PROVIDER PAGE 1 - INSURER/TPA PAGE 2 - EMPLOYEE PAGE 3 - EMPLOYEE PAGE 4 - EMPLOYEE FORM C-4 (REV. 2023)

HEALTHCARE PROVIDER RESPONSIBILITIES
Send C-4 to **Correct** Insurer/TPA



If C-4 ends up with the Incorrect Insurer/TPA



HCP submits C-4



2-3 Days



Incorrect Insurer/TPA



Days/Weeks/Months



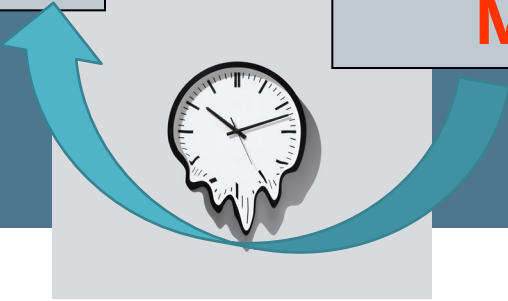
DIR/WCS



Correct Insurer/TPA



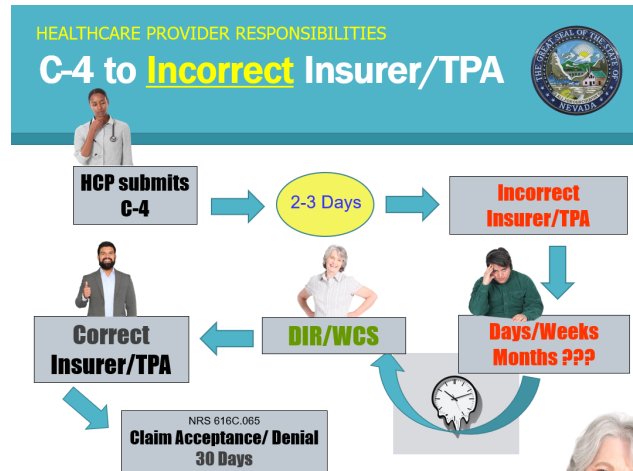
**NRS 616C.065
Claim Acceptance/Denial
30 Days**





HEALTHCARE PROVIDER RESPONSIBILITIES

If the WCS finds Employer without Workers' Compensation Coverage

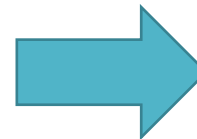


If the WCS is unable to find credible Workers' Compensation (WC) coverage for the employer of the injured employee, the case may be referred to the Employer Compliance Unit (ECU) for further investigation and compliance enforcement.



DIR/WCS/MU

MEDICAL UNIT



DIR/WCS/ECU

EMPLOYER COMPLIANCE UNIT

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
 PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM						PROVIDE ALL INFORMATION REQUESTED	
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)		
Mailing Address			Age	Height	Weight	Social Security Number	
City		State	Zip	Telephone			
Email Address					Primary Language Spoken		
INSURER		THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employer's Name/Company Name					Telephone		
Office Mail Address (Number and Street)							
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported			
Address or Location of Accident (if applicable)							
What were you doing at the time of the accident? (if applicable)							
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)							
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)		
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected				
I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.							
Date	Place	Employee's Original or Electronic Signature					

INJURED WORKER SECTION

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place			Name of Facility				
Date	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)					
Hour							
Treatment:		<input type="checkbox"/> No <input type="checkbox"/> Yes (patient to remain off work five days or more?) <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No, is (s) (s) able to perform: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____					
X-Ray Findings:							
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)							
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:				
Address			INSURER'S USE ONLY				
City	State	Zip				Provider's Tax I.D. Number	Telephone
Health Care Provider's Original or Electronic Signature						Degree (MD, DO, DC, PA-C, APRN)	
						Choose (if applicable)	

HEALTHCARE PROVIDER SECTION

C-4


TWO PARTS OF THE C-4 FORM

**NOT THE HEALTH
INSURANCE COMPANY!**

TO BE COMPLETED BY THE INJURED EMPLOYEE
Injured Employee Section

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED

First Name <i>John</i>	M.I. <i>Lloyd</i>	Last Name <i>Ortiz</i>	Birthdate <i>01/30/1972</i>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)
Mailing Address <i>7512 Java Sparrow St</i>		Age <i>52</i>	Height <i>5'10"</i>	Weight	Social Security Number <i>680-xx-xxx</i>
City <i>North Las Vegas</i>	State <i>Nevada</i>	Zip <i>89084</i>	Telephone		
Email Address <i>John.Lloyd@gmail.com</i>				Primary Language Spoken	
INSURER <i>American Mutual</i>	THIRD-PARTY ADMINISTRATOR <i>Zurwick</i>	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employer's Name/Company Name <i>Viva Marketing</i>				Telephone	
Office Mail Address (Number and Street) <i>7918 Bruce Street.</i>					
Date of Injury (if applicable) <i>07/09/24</i>	Hours Injury (if applicable) <i>am 1:18 pm</i>	Date Employer Notified <i>07/09/24</i>	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported <i>Bea Alonzo</i>	
Address or Location of Accident (if applicable) <i>7918 Bruce Street.</i>					
What were you doing at the time of the accident? (if applicable) <i>Walking down the hallway</i>					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary) <i>Slip and fall</i>					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? <i>Slip and fall</i>				Witnesses to the Accident (if applicable)	
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected <i>Knee and back</i>		
I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 615A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.					
Date	Place	Employee's Original or Electronic Signature 			



TO BE COMPLETED BY THE INJURED EMPLOYEE

Injured Employee Section



Employee Information

- First and last name
- **Date of birth**, address, and telephone number
- Email address

Employer Information

- **Correct** corporate name
- Doing Business As (DBA), if any
- **Employer** address and telephone number

Accident or Disease

- Date, time, and location of accident
- Describe the incident in specific details

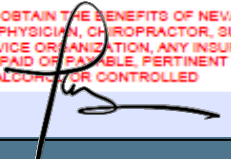


Complete the C-4 Form as soon as the injured employee is able.

TO BE COMPLETED BY THE INJURED EMPLOYEE

Injured Employee Section

Make sure the injured employee signs and dates the C-4 Form.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4 PLEASE TYPE OR PRINT							
EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED							
First Name	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurers Use Only)		
John	Lloyd	Cruz	01/30/1972	<input checked="" type="checkbox"/> M <input type="checkbox"/> F			
Mailing Address			Age	Height	Weight	Social Security Number	
7512 Java Sparrow St.			52	5'10"		680-xx-xxx	
City	State	Zip	Telephone				
North Las Vegas	Nevada	89084					
Email Address					Primary Language Spoken		
John.Lloyd@gmail.com							
INSURER	THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred				
American Mutual	Zurwick						
Employer's Name/Company Name					Telephone		
Viva Marketing							
Office Mail Address (Number and Street)							
7918 Bruce Street.							
Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported			
07/09/24	am 7:18 pm	07/09/24		Bea Alonzo			
Address or Location of Accident (if applicable)							
7918 Bruce Street.							
What were you doing at the time of the accident? (if applicable)							
Walking down the hallway							
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)							
Slip and fall							
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)		
Slip and fall							
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected				
			Knee and back				
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 515A TO 515D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>							
Date	Place	Employee's Original or Electronic Signature					
							

TO BE COMPLETED BY THE INJURED EMPLOYEE

Injured Employee Section

TO BE COMPLETED BY THE TREATING PHYSICIAN

Healthcare Provider Section



THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place <i>4041 Spring Line St.</i>	Name of Facility <i>Concentrate Clinic</i>	
Date <i>07/09/2024</i>	Diagnosis and Description of Injury or Occupational Disease <i>Strain on lower back and (R) knee</i>	Is there evidence that the injured employee was under the influence of alcohol and/or other controlled substance at the time of the accident? <i>(If yes, please explain)</i>
Hour <i>9:18 AM</i>	Treatment: <i>Conservative home therapies such as Tylenol, NSAID, ice.</i>	Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input checked="" type="checkbox"/> No If no, is the injured employee capable of: <input checked="" type="checkbox"/> full duty <input type="checkbox"/> modified duty
X-Ray Findings: <i>none</i>	From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If modified duty, specify any limitations/restrictions: _____
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Explain if yes)	
Date <i>07/09/2024</i>	Print Health Care Provider's Name <i>Dr. Lepper</i>	I certify that the employer's copy of this form was delivered to the employer on:
Address <i>4041 Spring Line St.</i>	INSURER'S USE ONLY	
City <i>N. Las Vegas NV</i>	State <i>NV</i>	Zip <i>89121</i>
Provider's Tax ID Number <i>99-84512-72</i>	Telephone <i>702-684-5213</i>	
Health Care Provider's Original or Electronic Signature <i>[Signature]</i>	Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)	

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.08/23)

What HCPs may sign a C-4 Form?

- MD
- DO
- DC
- APRN
- PA



TO BE COMPLETED BY THE TREATING PHYSICIAN

Healthcare Provider Section

D-2 Form

Brief Description of Rights and Benefits

Must be provided to the injured employee at the time of treatment

(NRS 616C.095)

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS (Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Employee's Claim for Compensation/Report of Initial Treatment (Form C-4): If medical treatment is sought, the Form C-4 is available at the place of initial treatment. A completed Form C-4 must be filed within 90 days after an accident or OD. The treating physician, chiropractic physician, physician assistant or advanced practice nurse must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractic physician from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractic physician from the Panel of Physicians and Chiropractic Physicians. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractic physician to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractic physician as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer**, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeals Officer's decision. You may be represented by an attorney at your own expense, or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a Hearing Officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 1886 East College Pkwy. Ste. 100, Carson City, NV 89706, telephone (775) 684-7270, or 3360 West Sahara Avenue, Suite 250, Las Vegas, Nevada 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 7150 Pollock Drive, Las Vegas, NV 89119, Toll Free 1-888-333-1597, Web site: [https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)) E-mail: cha@govcha.nv.gov

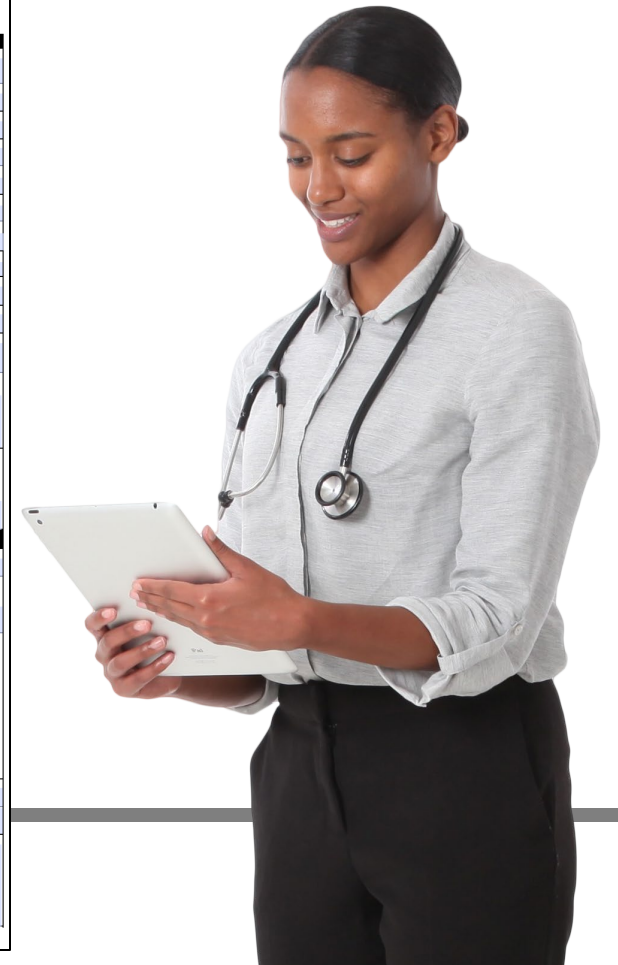
Healthcare Provider Responsibilities

- Use form prescribed by DIR.
- C-4 Forms are available on the WCS website.
- May NOT modify or edit state-mandated forms without the prior approval of the Administrator

Within 3 working days, complete and file the C-4 Form with the employer and **CORRECT** insurer/TPA.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4 PLEASE TYPE OR PRINT EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED					
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (insurers use only)
Mailing Address		Age	Height	Weight	Social Security Number
City		State	Zip	Telephone	
Email Address				Primary Language Spoken	
INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employer's Name/Company Name				Telephone	
Office Mail Address (Number and Street)					
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported	
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?				Witnesses to the Accident (if applicable)	
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected		
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES (NRS 618A TO 618D, INCLUDING OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS AND PAYABLE PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>					
Date	Place	Employee's Original or Electronic Signature			
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT					
Place Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease				Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)
Hour					
Treatment:			Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____		
X-Ray Findings:					
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)					
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:		
Address					
INSURER'S USE ONLY					
City	State	Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN)		
			Choose if applicable		

ORIGINAL - TREATING HEALTHCARE PROVIDER PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev.02/25)



Healthcare Provider Responsibilities



- Exert all efforts to find the correct insurer or Third-Party Administrator (TPA).
- Maintain sufficient supply of appropriate forms.
- Always use the latest version of this form (2/25).

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4 PLEASE TYPE OR PRINT PROVIDE ALL INFORMATION REQUESTED					
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer Use Only)
Mailing Address	Age	Height	Weight	Social Security Number	
City	State	Zip	Telephone		
Email Address					Primary Language Spoken
INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employee's Name (Company Name)					
Office Mail Address (Number and Street)					
Date of Injury or event(s)	Hours (Injury if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported	
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected		
<small>VERIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THE INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF MY WORKERS COMPENSATION AND OCCUPATIONAL DISEASE ACTS AND STATE TO THE BEST OF MY KNOWLEDGE OR CHAPTER 411 OF HRSA. I HEREBY AUTHORIZE ANY PERSON, CONTRACTOR, SUBCONTRACTOR OR ANY OTHER PERSON, AND AGENT, INCLUDING VERBALE, ADVANTAGE OR DISCOUNTS, TO OBTAIN ANY MEDICAL SERVICES OR OPERATIONS AND ANY OCCUPATIONAL DISEASE ACTS BENEFITS OR RELATIONSHIP TO OBTAIN TO BE RELEASED TO THE PUBLIC AND ANY INFORMATION, INCLUDING BENEFIT AND OR PAYABLE, PERTAINING TO THIS CLAIM. I AGREE TO RELEASE TO THE PUBLIC AND ANY INFORMATION, INCLUDING BENEFIT AND OR PAYABLE, PERTAINING TO THIS CLAIM. I AGREE TO RELEASE TO THE PUBLIC AND ANY INFORMATION, INCLUDING BENEFIT AND OR PAYABLE, PERTAINING TO THIS CLAIM. I AGREE TO RELEASE TO THE PUBLIC AND ANY INFORMATION, INCLUDING BENEFIT AND OR PAYABLE, PERTAINING TO THIS CLAIM.</small>					
Date: _____ Place: _____ Employee's Original or Electronic Signature: _____					
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT					
Date	Diagnosis and Description of Injury or Occupational Disease			Is there evidence that the injured employee was under the influence of alcohol or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please specify)	
Hour	Treatment:			Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No, is the injured employee capable of full duty <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____	
X-Ray Findings:					
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (If/when if yes)					
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:		
Address			INSURER'S USE ONLY		
City	State	Zip	Provider's Tax ID Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN)		
			Check (if applicable)		

ORIGINAL - TREATING HEALTHCARE PROVIDER PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev. 02/25)

Healthcare Provider Responsibilities

Proof of Coverage (POC) Call:

If you have difficulty identifying the correct insurer/TPA, call the WCS for assistance within the 3 working days.



(702) 486-9080

Only send the C-4 Form to the WCS if directed to do so by WCS staff. **You will be provided a reference number** and directed to email the C-4 Form to medunit@dir.nv.gov.

WCS fines HCPs for untimely or incomplete C-4 Form submission to correct insurer/TPA.



VERY IMPORTANT

BEFORE YOU SEND THE C-4 FORM TO ANYONE

1. If possible, ask the injured employee to provide all EMPLOYER information.
2. If you cannot identify the correct insurer or TPA, use the Coverage Verification Service (CVS) on the WCS website: <http://dir.nv.gov/WCS/home/>.
3. Use other resources, such as the Claims and Regulatory Data System (CARDS), Coverage Verification Service (CVS), the Division of Insurance Self-Insured and Associations lists, business license searches, Nevada State Contractors Board, etc.
4. If unable to locate the insurer or TPA through CARDS, CVS, or other searches, contact the employer, and document the response.
5. If unable to locate coverage information after following the above steps, call the **WCS** at (702) 486-9080. If the **WCS** is unable to locate coverage over the telephone, you will be provided a reference number and directed to email the C-4 Form and documentation to medunit@dir.nv.gov for further investigation.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED					
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (insurer's Use Only)
Mailing Address		Age	Height	Weight	Social Security Number
City	State	Zip	Telephone		
Email Address					Primary Language Spoken
INSURER		THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred	
Employer's Name/Company Name					Telephone
Office Mail Address (Number and Street)					
Date of Injury (if applicable)	Hours of Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported	
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected		
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTERS 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR ADD, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>					
Date	Place	Employee's Original or Electronic Signature			
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT					
Place Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease			Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)	
Hour	Treatment:			Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____	
X-Ray Findings:					
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)					
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:		
Address					INSURER'S USE ONLY
City	State	Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN) Choose if applicable		

ORIGINAL - TREATING HEALTHCARE PROVIDER PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev.02/05)

END OF C-4 TRAINING

First part of training

COVERAGE VERIFICATION SERVICE

Second part of training

Why verify WC coverage?

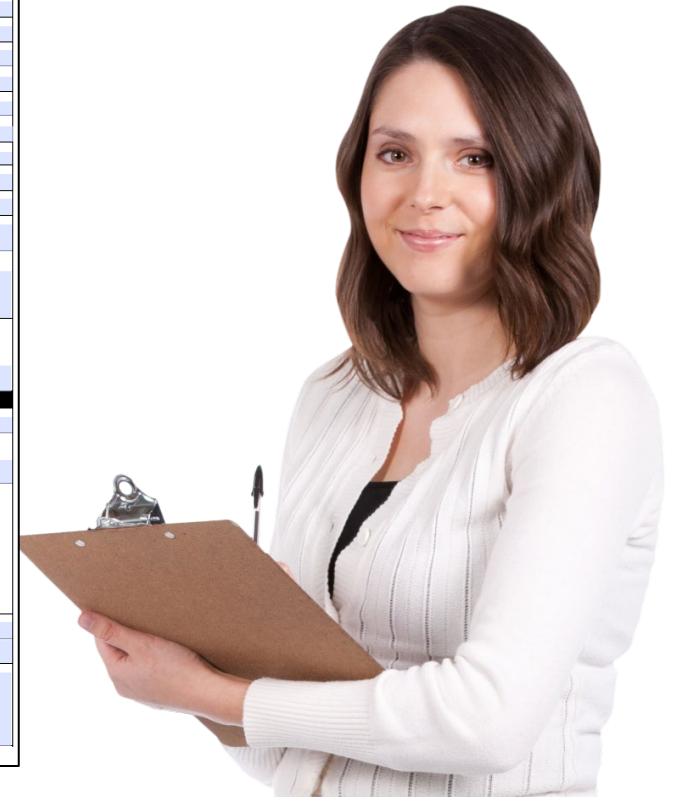
NRS 616C.040 requires healthcare providers (HCPs), within 3 days of initially evaluating the injured employee, complete and file Employee's Claim for Compensation/Report of Initial Treatment (C-4 Form) and send it to the correct insurer or TPA.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM		PROVIDE ALL INFORMATION REQUESTED			
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer Use Only)
Mailing Address		Age	Height	Weight	Social Security Number
City	State	Zip	Telephone		
Email Address				Primary Language Spoken	
INSURER	THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred		
Employer's Name/Company Name				Telephone	
Office Mail Address (Number and Street)					
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported	
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?				Witnesses to the Accident (if applicable)	
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected		
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL, HOSPITAL, AND MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR ADDITIONAL PSYCHOLOGICAL CONDITIONS, ALCOHOL, OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS AN ORIGINAL.</small>					
Date	Place	Employee's Original or Electronic Signature			
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT					
Place Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease				Is there evidence that the injured employee was under the influence of alcohol or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)
Hour	Treatment:				Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes indicate dates: from _____ to _____ <input type="checkbox"/> No if no, is the injured employee capable of <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____
X-Ray Findings:	From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)					
Date	Print Health Care Provider's Name		I certify that the employer's copy of this form was delivered to the employer on:		
Address			INSURER'S USE ONLY		
City	State	Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)		

ORIGINAL - TREATING HEALTHCARE PROVIDER PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev.02/25)



This training will assist healthcare providers identify the correct TPA and Insurer so they can send the C-4 form in a timely manner.

What is Coverage Verification?

Coverage Verification refers to the process of verifying a specific employer's Workers' Compensation (WC) insurer and or Third-Party Administrator (TPA) on the injured employee's date of injury/exposure.



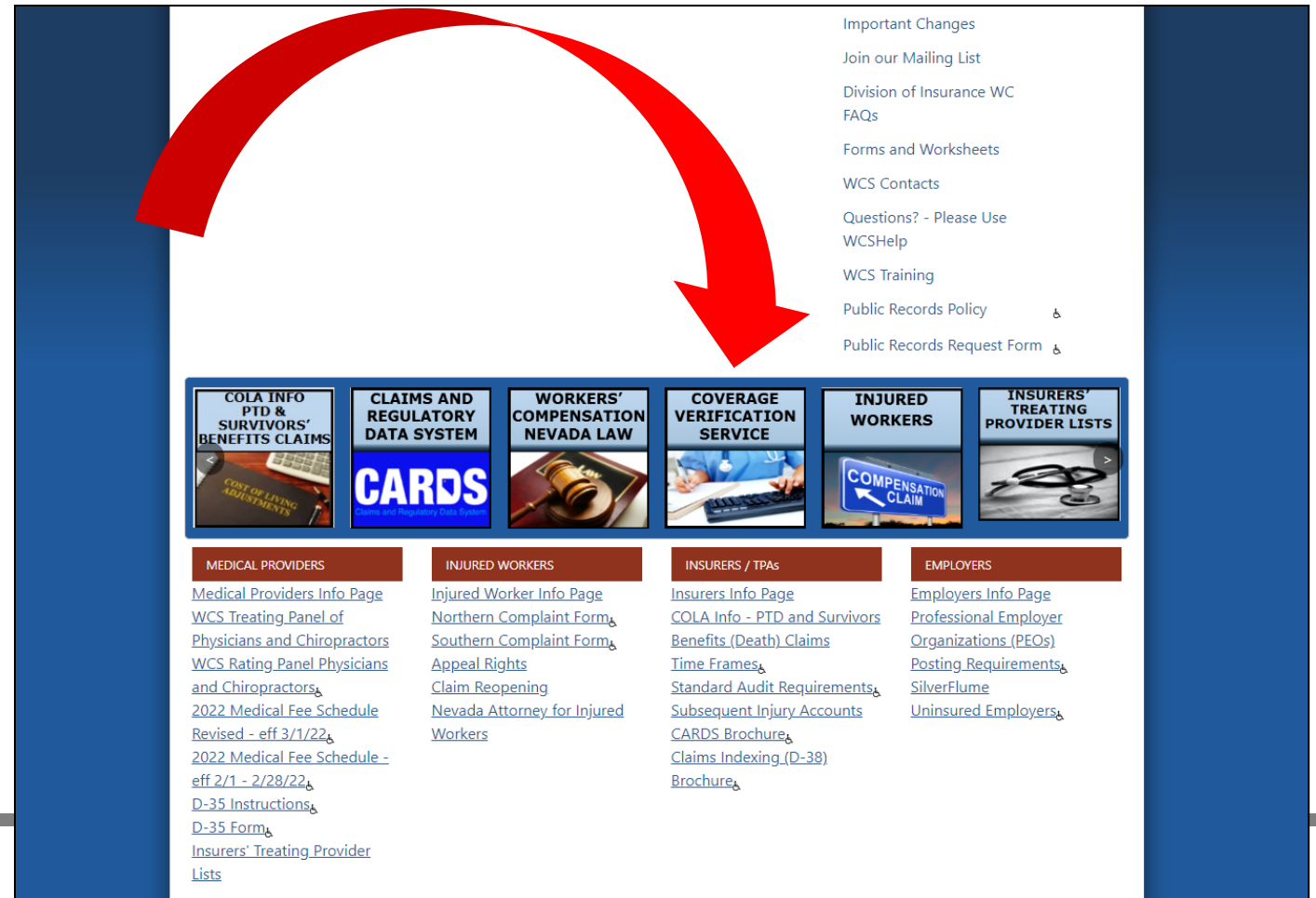
What is CVS?

CVS stands for Coverage Verification Service.

There is a link to CVS on the Workers' Compensation Section (WCS) homepage at <https://dir.nv.gov/WCS/home/>.

CVS is used to search for an employer's private workers' compensation insurer on a given date.

<http://dir.nv.gov/WCS/home/>



The screenshot shows the Nevada Workers' Compensation Section (WCS) homepage. A large red arrow points from the top right towards the 'COVERAGE VERIFICATION SERVICE' link in the navigation menu. The navigation menu includes links for 'COLA INFO PTD & SURVIVORS' BENEFITS CLAIMS', 'CLAIMS AND REGULATORY DATA SYSTEM CARDS', 'WORKERS' COMPENSATION NEVADA LAW', 'COVERAGE VERIFICATION SERVICE', 'INJURED WORKERS COMPENSATION CLAIM', and 'INSURERS' TREATING PROVIDER LISTS'. Below the navigation menu, there are four columns of links: 'MEDICAL PROVIDERS', 'INJURED WORKERS', 'INSURERS / TPAs', and 'EMPLOYERS'. The 'COVERAGE VERIFICATION SERVICE' link is highlighted in the navigation menu.

Important Changes
Join our Mailing List
Division of Insurance WC
FAQs
Forms and Worksheets
WCS Contacts
Questions? - Please Use
WCSHelp
WCS Training
Public Records Policy &
Public Records Request Form &

COLA INFO PTD & SURVIVORS' BENEFITS CLAIMS
CLAIMS AND REGULATORY DATA SYSTEM CARDS
WORKERS' COMPENSATION NEVADA LAW
COVERAGE VERIFICATION SERVICE
INJURED WORKERS COMPENSATION CLAIM
INSURERS' TREATING PROVIDER LISTS

MEDICAL PROVIDERS
[Medical Providers Info Page](#)
[WCS Treating Panel of Physicians and Chiropractors](#)
[WCS Rating Panel Physicians and Chiropractors](#)
[2022 Medical Fee Schedule Revised - eff 3/1/22](#)
[2022 Medical Fee Schedule - eff 2/1 - 2/28/22](#)
[D-35 Instructions](#)
[D-35 Form](#)
[Insurers' Treating Provider Lists](#)

INJURED WORKERS
[Injured Worker Info Page](#)
[Northern Complaint Form](#)
[Southern Complaint Form](#)
[Appeal Rights](#)
[Claim Reopening](#)
[Nevada Attorney for Injured Workers](#)

INSURERS / TPAs
[Insurers Info Page](#)
[COLA Info - PTD and Survivors Benefits \(Death\) Claims](#)
[Time Frames](#)
[Standard Audit Requirements](#)
[Subsequent Injury Accounts](#)
[CARDS Brochure](#)
[Claims Indexing \(D-38\) Brochure](#)

EMPLOYERS
[Employers Info Page](#)
[Professional Employer Organizations \(PEOs\)](#)
[Posting Requirements](#)
[SilverFlume](#)
[Uninsured Employers](#)

CVS Limitations



- Includes only employers with private insurers
- Employers that are self-insured, employers that are part of associations, or uninsured employers will not be listed
- In Coverage Date, enter the **date of injury** rather than the date of the search.
- The accuracy of the information depends on the accuracy of the information provided by insurers.

* Searches resulting in NO MATCHES do not necessarily indicate coverage does not exist.

Who has access to CVS?



- **Injured employees**
- **HCPs**
- **Insurers/TPAs**
- **Attorneys**
- **General contractors**
- **Public**

Where do we begin our search?

Start with the
C4-Form

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4 PLEASE TYPE OR PRINT				
EMPLOYEE'S CLAIM		PROVIDE ALL INFORMATION REQUESTED		
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address		Age	Height	Weight
City	State	Zip	Telephone	
Email Address			Primary Language Spoken	
INSURER		THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
Employer's Name/Company Name			Telephone	
Office Mail Address (Number and Street)				
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
Address or Location of Accident (if applicable)				
What were you doing at the time of the accident? (if applicable)				
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)				
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?				Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease		Part(s) of Body Injured or Affected		
<small>I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR ADDICTION, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>				
Date	Place	Employee's Original or Electronic Signature		
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT				
Place	Name of Facility			
Date	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)		
Hour		Have you advised the patient to remain off work five days or more? <input checked="" type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty		
Treatment:		If modified duty, specify any limitations/restrictions: _____		
X-Ray Findings:				
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)				
Date	Print Health Care Provider's Name	I certify that the employer's copy of this form was delivered to the employer on:		
Address				INSURER'S USE ONLY
City	State	Zip	Provider's Tax I.D. Number	
Health Care Provider's Original or Electronic Signature		Telephone	Degree (MD, DO, DC, PA-C, APRN)	
			Choose (if applicable)	



Steps for Obtaining Insurance Information

Step 1 Ask the injured employee to **verify the employer name, address and telephone number.**

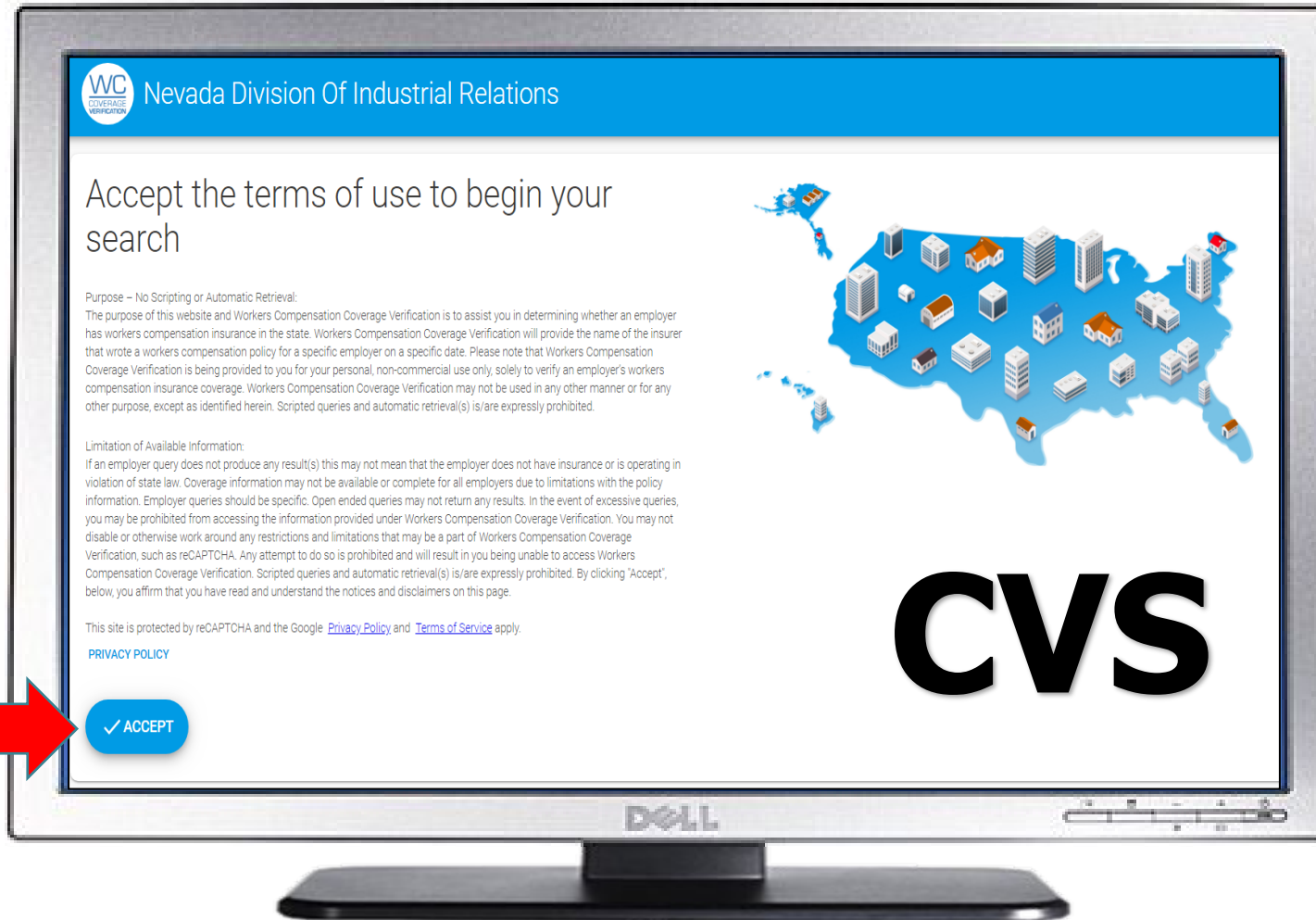
Step 2 Use CVS on the WCS website <http://dir.nv.gov/WCS/home/>.



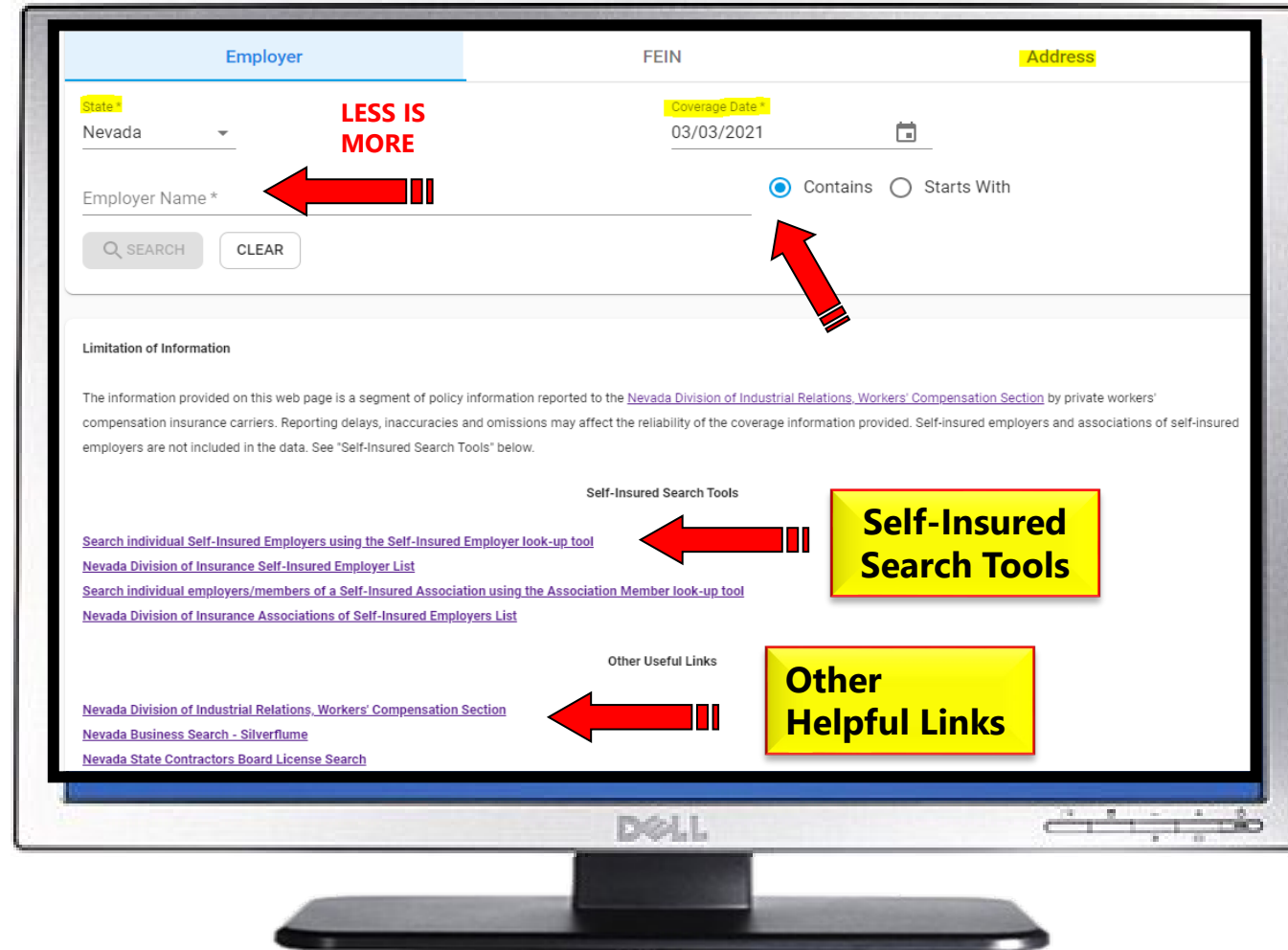
Coverage Verification Service



CVS Notice and Disclaimer Page



Date of Injury & Employer Information



Policy Information

The screenshot shows a web application interface for finding policy information. It features a search form with the following fields and options:

- Employer** (selected tab)
- State ***: Nevada
- Coverage Date ***: 01/30/2024
- Employer Name ***: West Sahara
- Search Options**: Contains, Starts With
- Buttons**: SEARCH, CLEAR

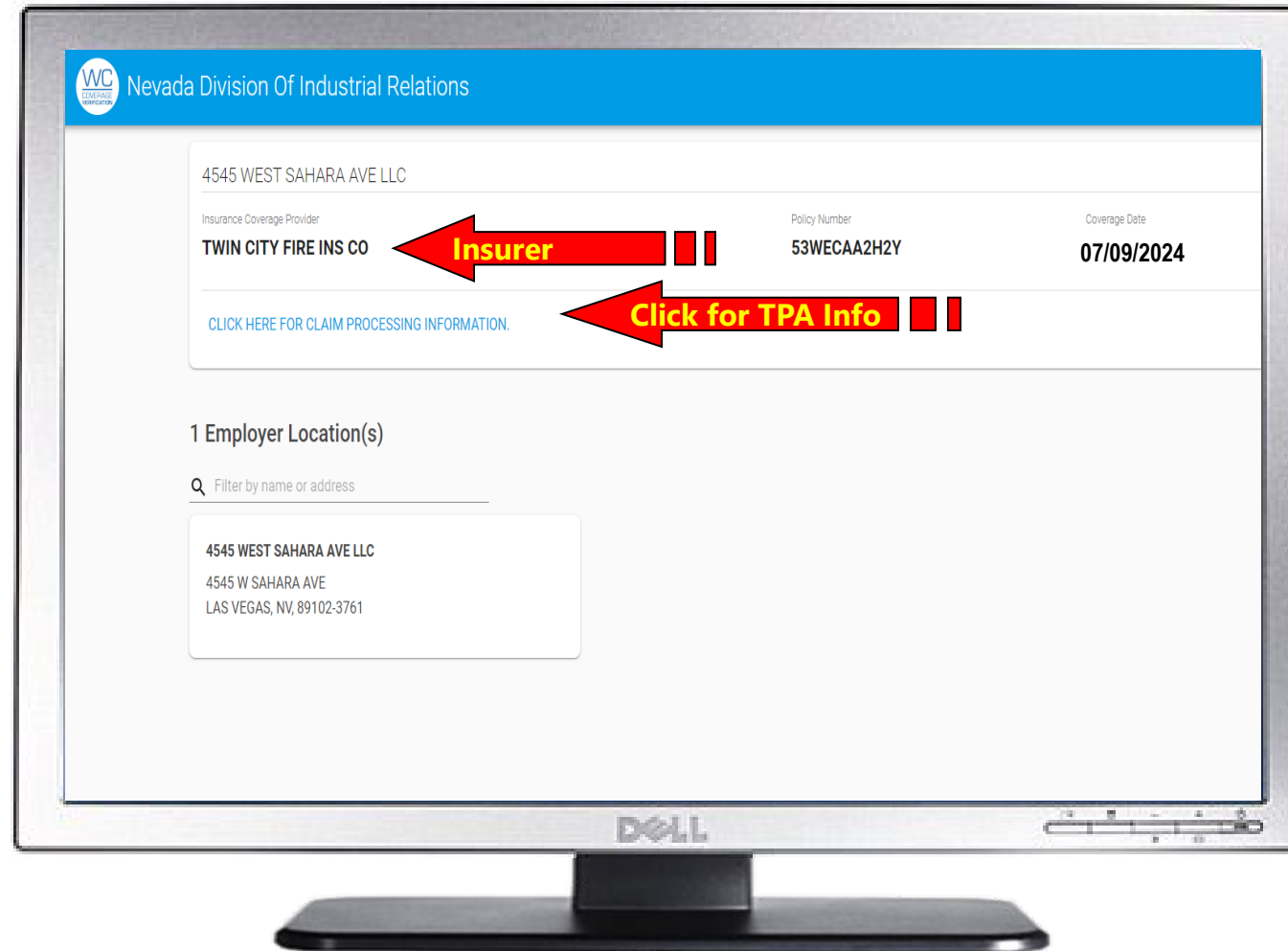
Below the search form is a list of search results, each with a company name, address, and policy number:

- FLETCHER JONES LAS VEGAS INC FLETCHER JONES WEST SAHARA LTD LLC DBA FLE**
7300 W SAHARA AVE, LAS VEGAS, NV, 89117-2756
Policy Number: 9021001002
- WEST SAHARA COMMUNITY ASSN**
2724 TIDEWATER CT, LAS VEGAS, NV, 89117-2447
Policy Number: A1520588423
- WEST SAHARA COMMUNITY ASSN**
8966 SPANISH RIDGE AVE # 100, LAS VEGAS, NV, 89148-1302
Policy Number: A1520588423
- WEST SAHARA JEWELERS**
2550 S RAINBOW BLVD STE E3, LAS VEGAS, NV, 89146-5178
Policy Number: 1871869
- 4545 WEST SAHARA AVE LLC**
4545 W SAHARA AVE, LAS VEGAS, NV, 89102-3761
Policy Number: 53WECAA2H2Y

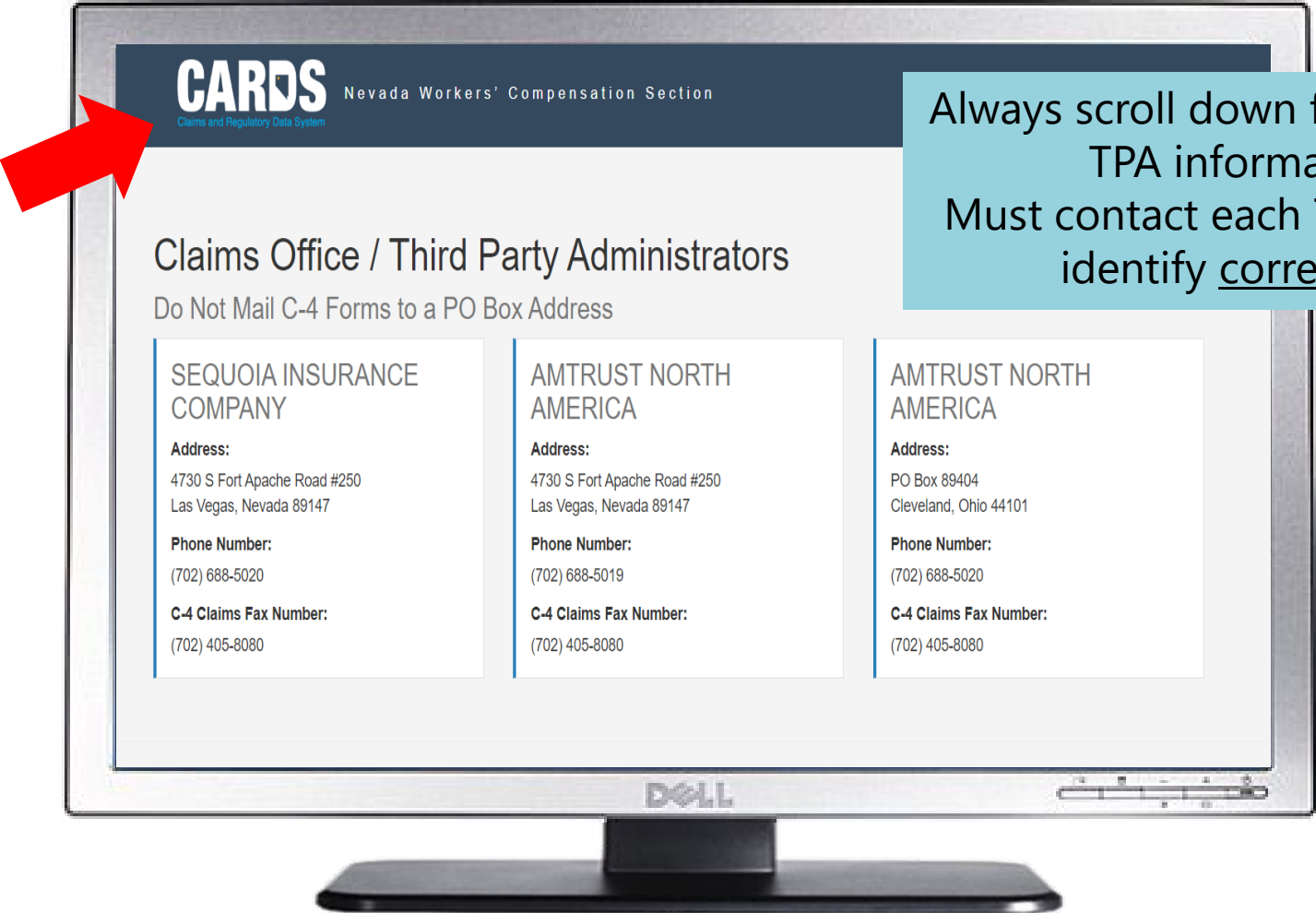
Annotations on the screenshot include:

- A red arrow pointing to the **Coverage Date *** field.
- A red arrow pointing to the **Employer Name *** field.
- A yellow sticky note with a red pushpin that says "Helpful Tips".
- A blue box with white text that says "When entering addresses, use one-letter directionals (i.e. N,S,E,W).".
- A red arrow pointing to the last search result, **4545 WEST SAHARA AVE LLC**, with the text "Click on correct employer" in yellow.

Policy/TPA Information



TPA Information/CARDS



Always scroll down for additional TPA information.
Must contact each TPA listed to identify correct TPA

Steps for Obtaining Insurance Information

***If unable to locate the insurer/TPA on CVS, follow step 3.
If insurer/TPA is found on CVS, skip to step 4.**

Step 3 Go to the Division of Insurance (DOI) website at <http://doi.nv.gov/>. Hover on the "Quick Links" tab to click "Self-Insured Workers' Compensation". Select either "Self-Insured Employer List" or "Association List."

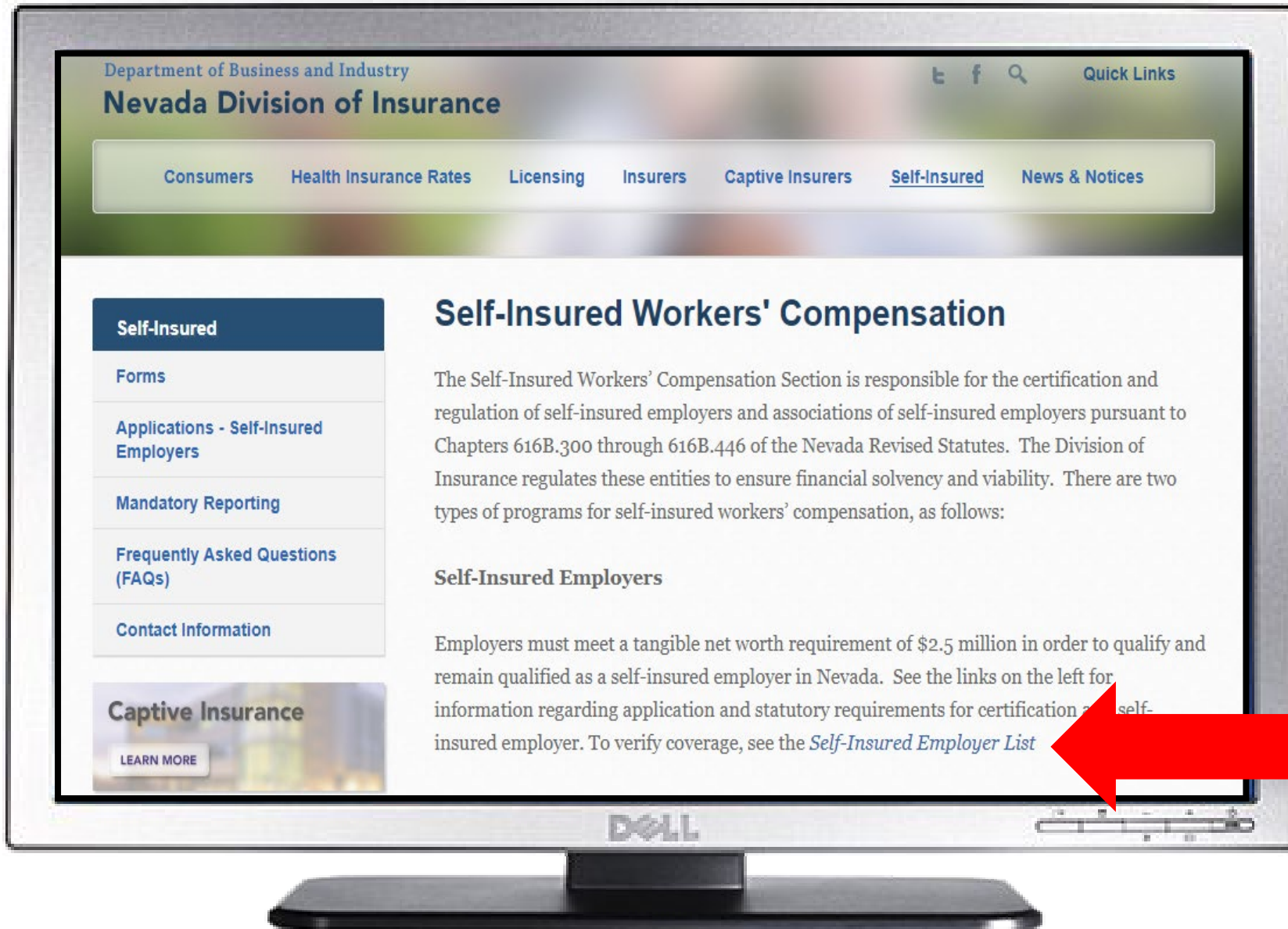


Self-Insured Employer Lookup: Nevada Division of Insurance

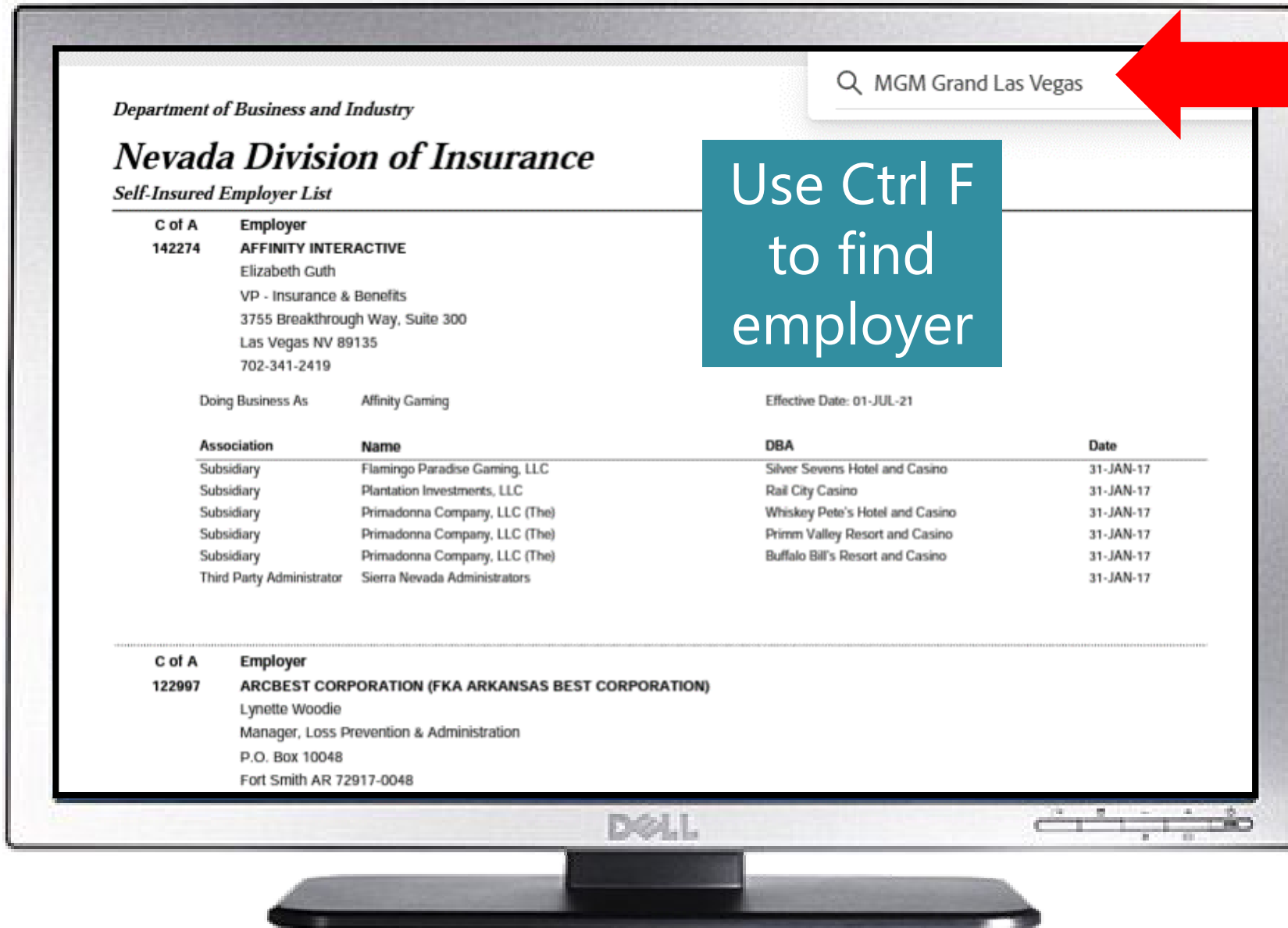
<http://doi.nv.gov/>



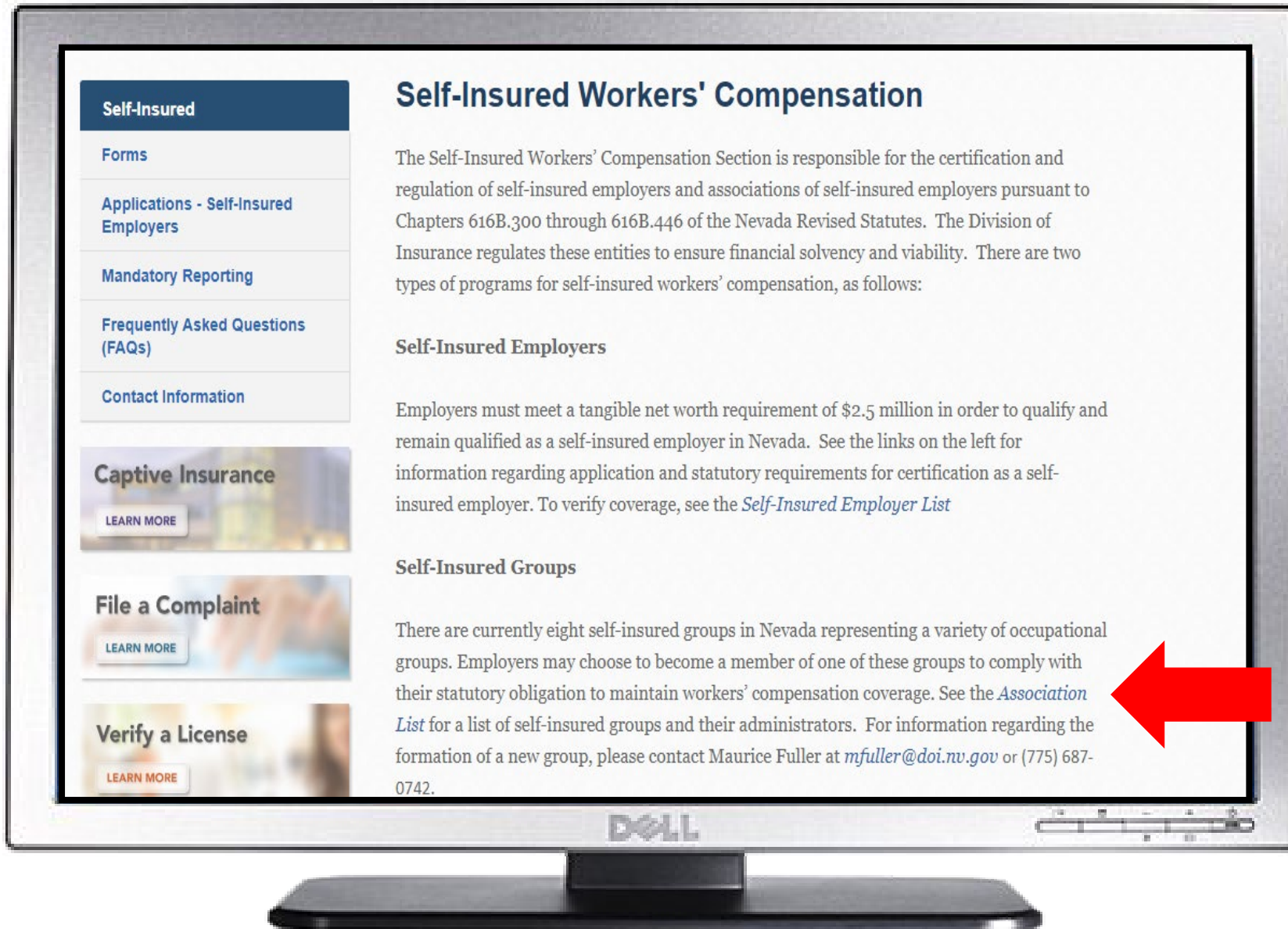
Self-Insured Employer Lookup: Nevada Division of Insurance



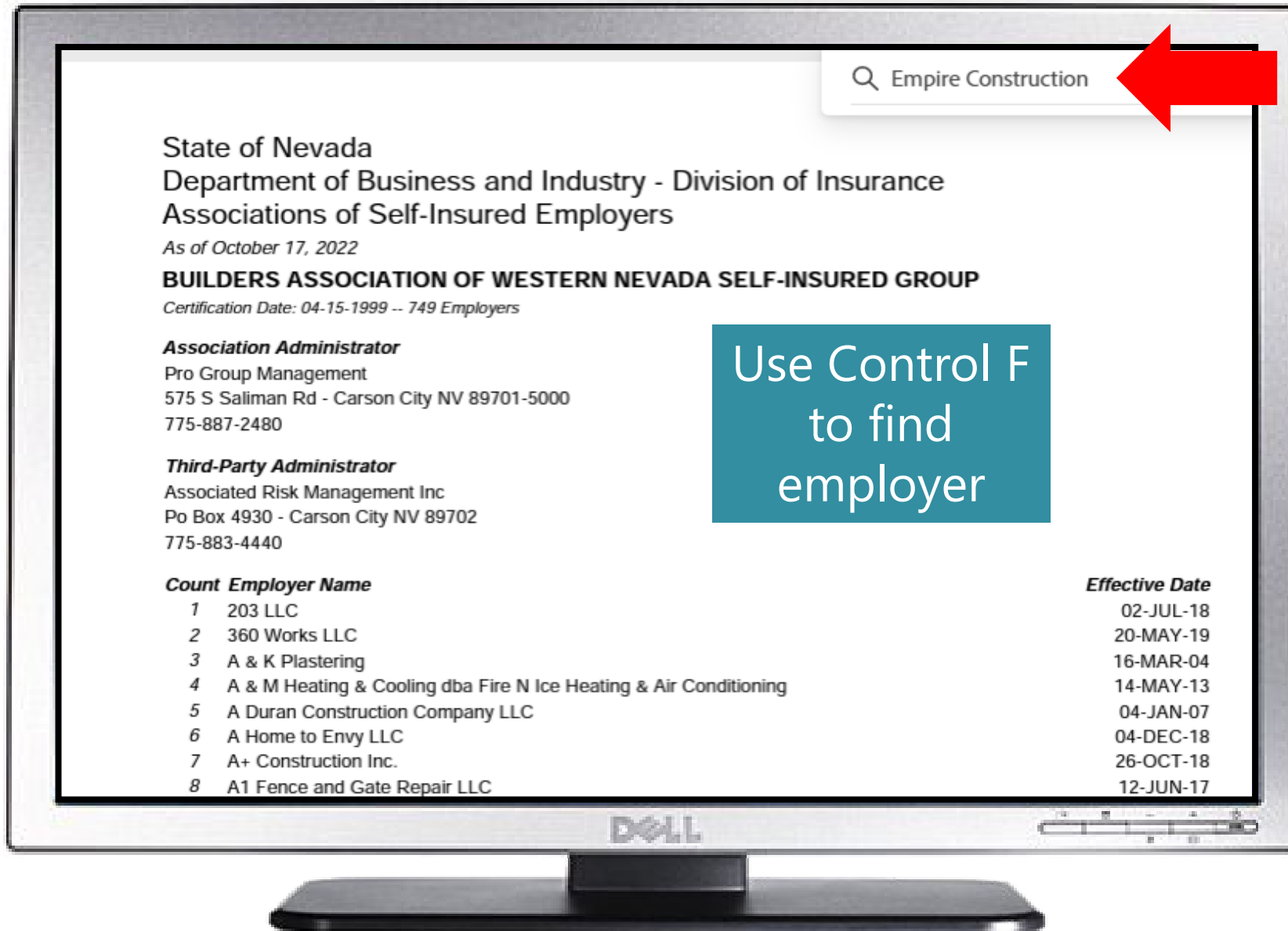
Self-Insured Employer Lookup: Nevada Division of Insurance



Self-Insured Association Member Lookup: Nevada Division of Insurance



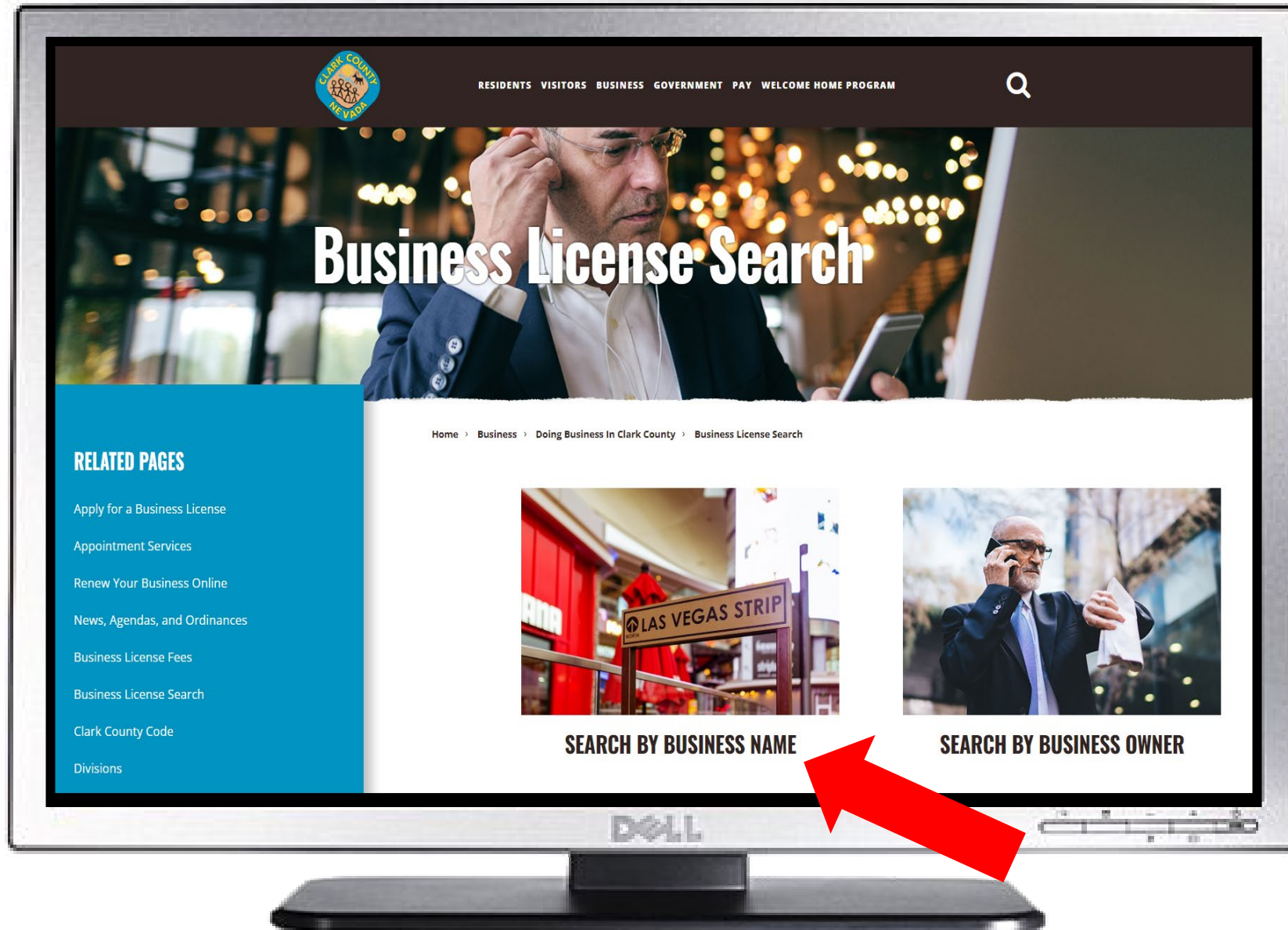
Self-Insured Association Member Lookup: Nevada Division of Insurance



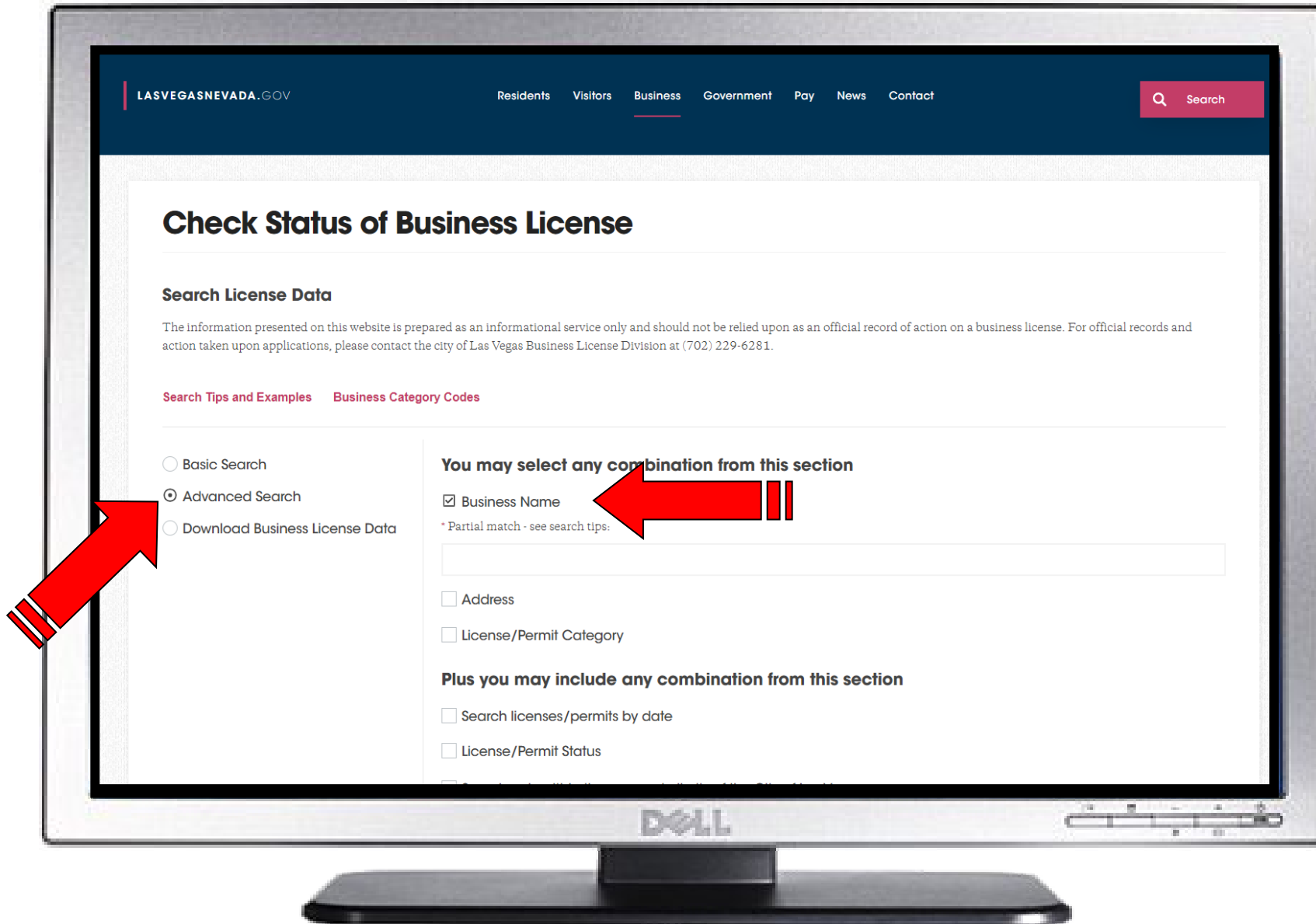
**But what if I
can't find it
in CVS?**



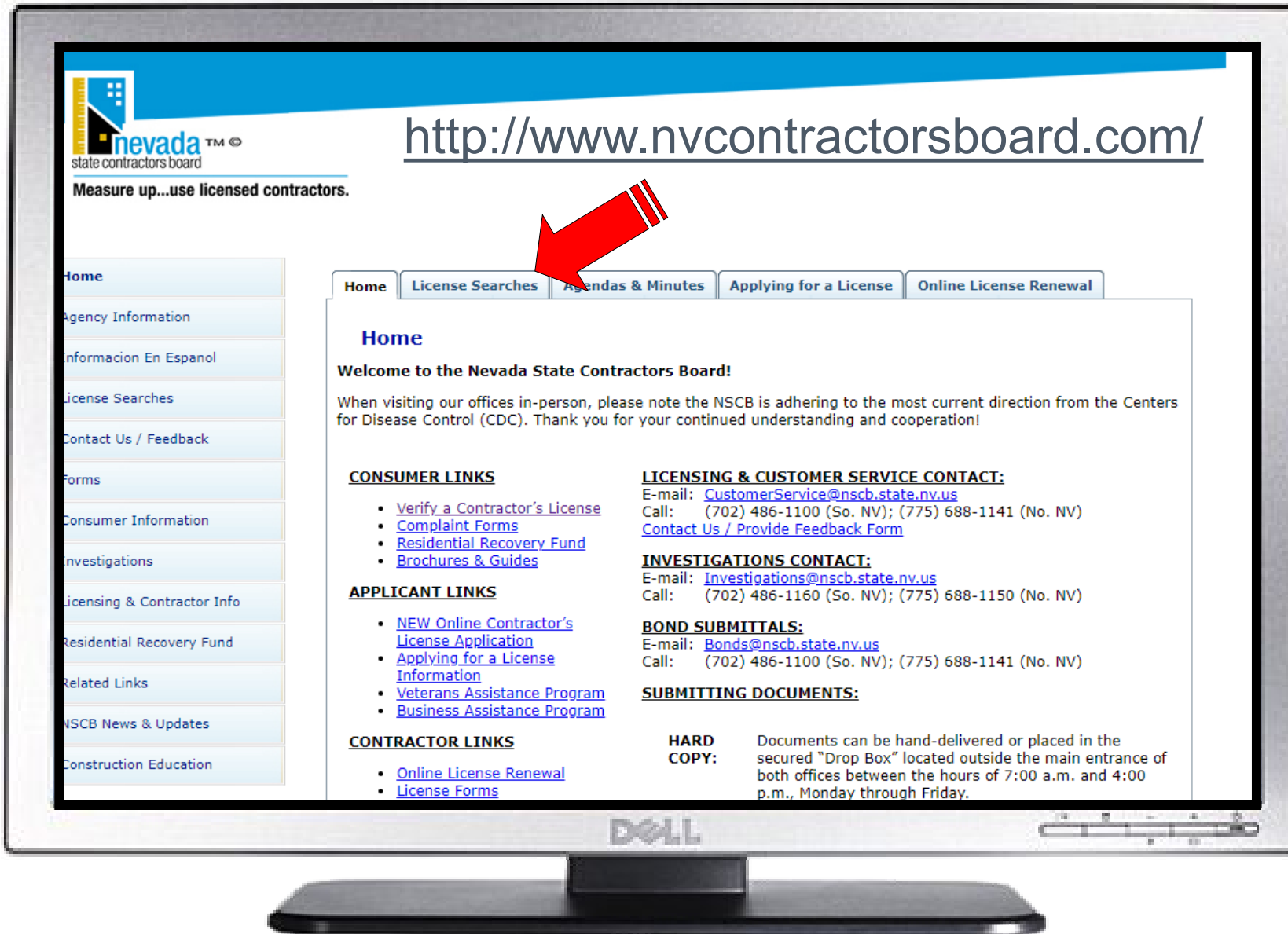
Business Name Lookup: Clark County Business License Search



Business Name Lookup: Clark County Business License Search



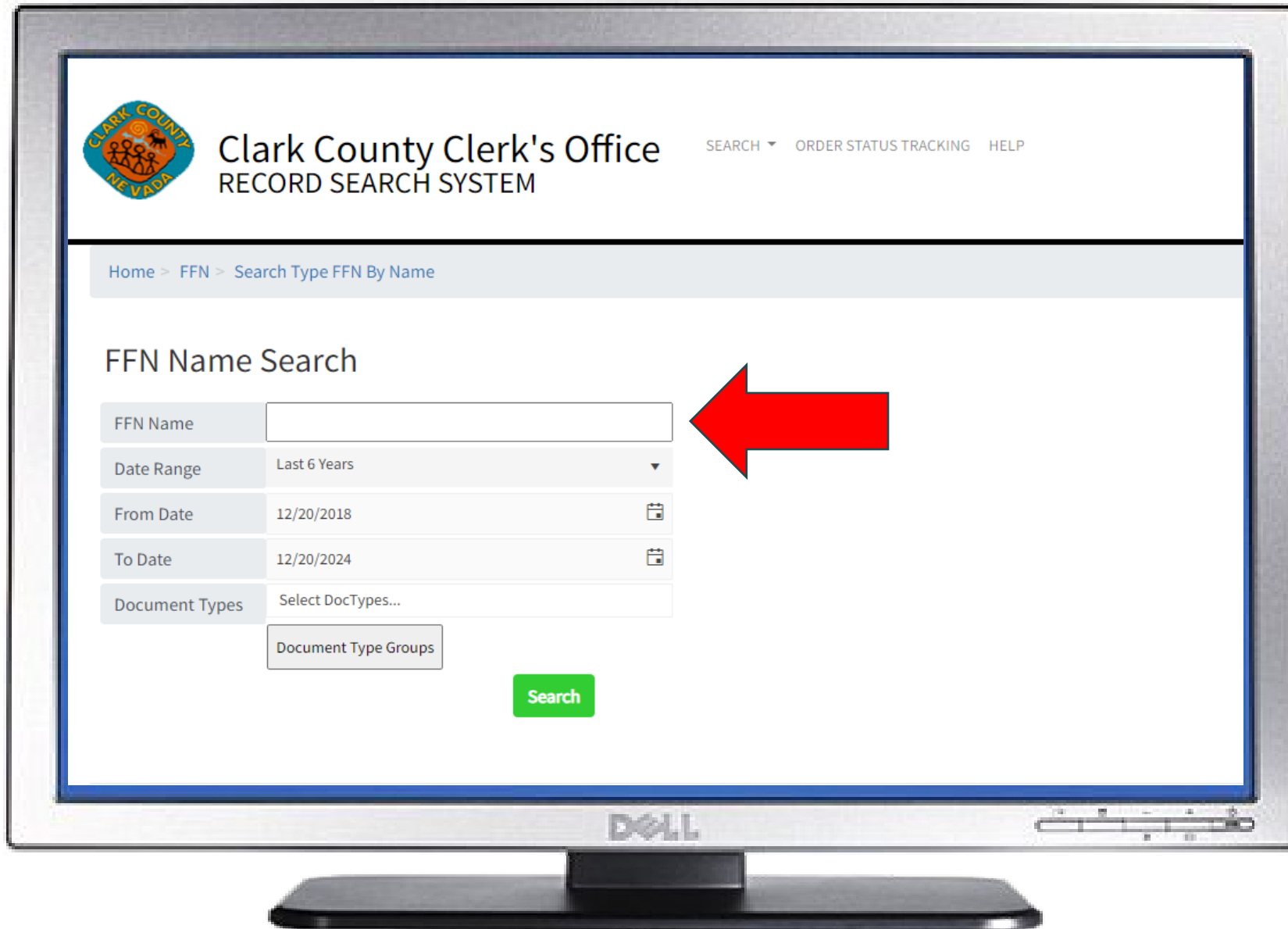
Business Name Lookup: Nevada Contractors Board



Business Entity Search: SilverFlume



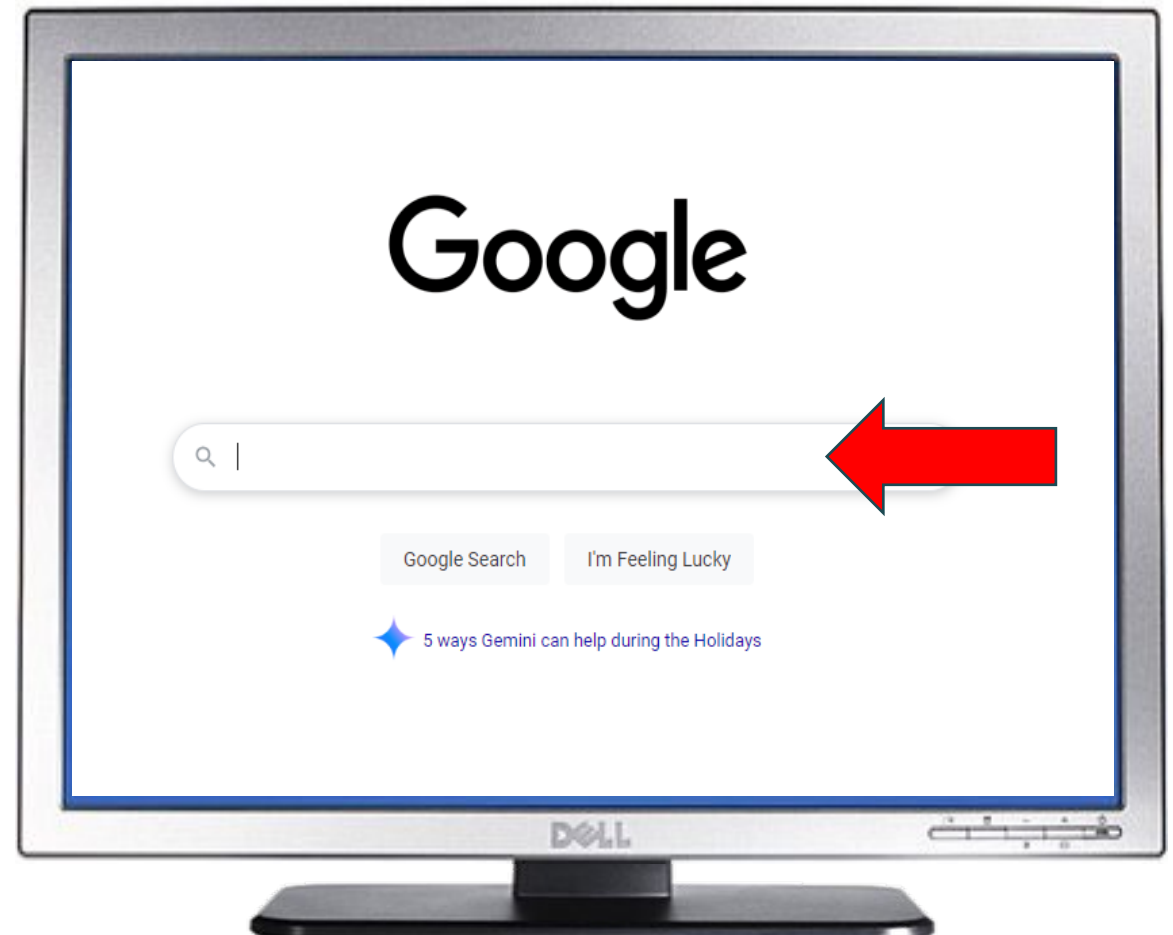
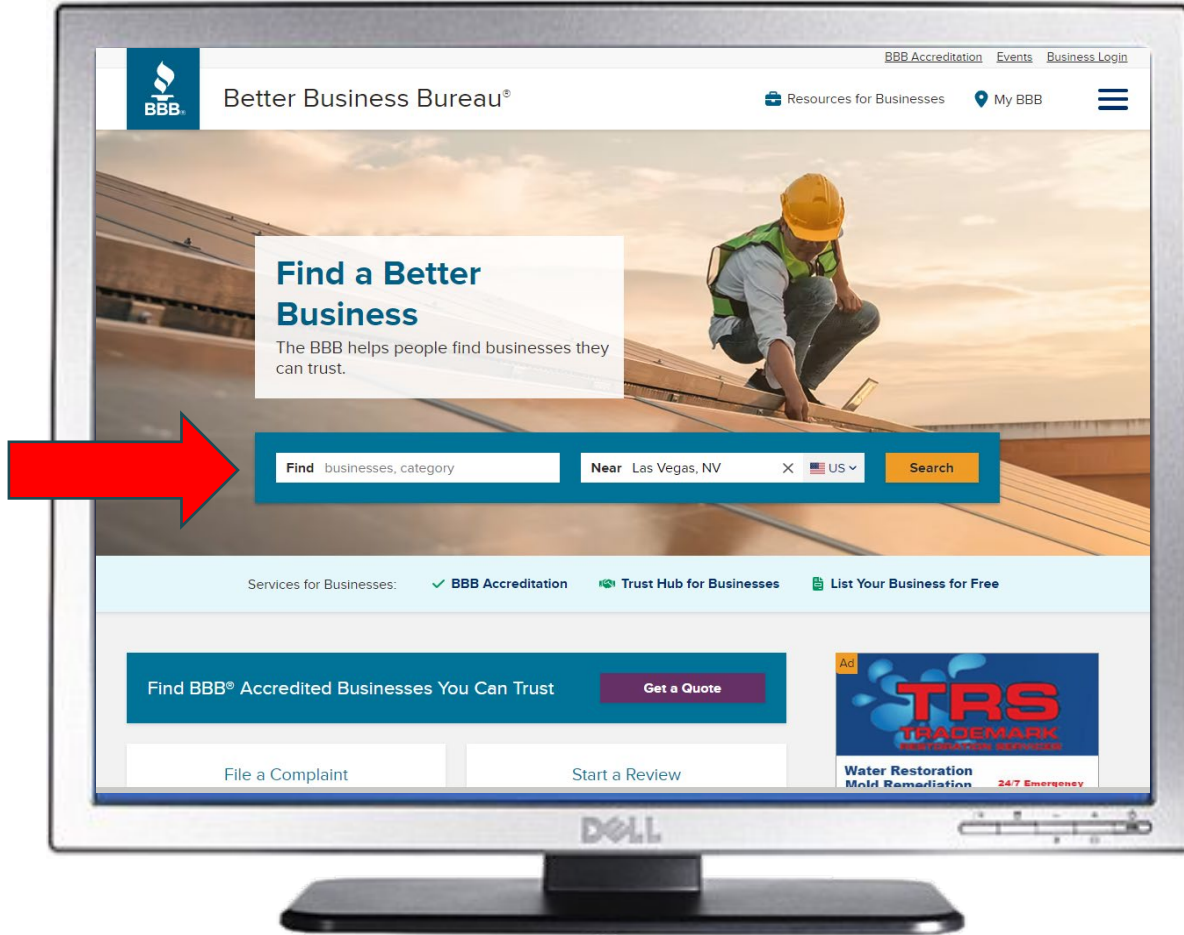
DBA Search: Clark County Fictitious Names



Employer Phone Number Search: 411.com



Other Resources: Better Business Bureau, Google Search, Etc.



Steps for Obtaining Insurance Information

Step 4 **ALWAYS** verify coverage with the correct insurer/TPA before sending the C-4 Form.

Step 5 If unable to locate the insurer/TPA through CVS or Self-Insured Workers' Compensation, contact the employer and document the response.

Step 6 If unable to locate coverage information after following the above steps, call the **WCS** at (702) 486-9080. If the **WCS** is unable to locate coverage over the telephone, **you will be provided a reference number** and directed to email Form C-4 and documentation for further investigation.



Federal Government Claims

Federal government workers' compensation claims:

U.S. Department of Labor (DOL)

Office of Workers' Compensation Programs (OWCP)

PO Box 8311

London, KY 40742-8300

1-866-335-8319

<http://www.dol.gov/owcp/>



Medical Unit Contacts

Proof of Coverage (POC)

Call (702) 486-9080

ONLY if directed by WCS staff,
email C-4 Forms to
medunit@dir.nv.gov.



Welcome to Workers' Compensation /RB

NOW ACCEPTING NEW APPLICATIONS FOR THE

WCS RATING PANEL OF PHYSICIANS AND CHIROPRACTORS

- click here to access the updated application -

WCS Rating Panel of Physicians and Chiropractors Application

What's Hot!

- **NOTICE** Emergency Regulation Regarding Lump Sum Payments of Permanent Partial Disability Awards - effective 12/5/2022
- **NEW** FY20 & FY21 Claims Activity Reports
- Hearings / Workshops / Meetings
- WCS Nevada Revised Statutes (NRS)
- WCS Nevada Administrative Code (NAC)
- Current Newsletter
- Important Changes
- Join our Mailing List
- Division of Insurance WC FAQs
- Forms and Worksheets
- WCS Contacts
- Questions? - Please Use WCSHelp
- WCS Training
- Public Records Policy
- Public Records Request Form

EMPLOYER COMPLIANCE

INSURER AND TPA REPORTING

COLA INFO PTID & SURVIVORS' BENEFITS CLAIMS

CLAIMS AND REGULATORY DATA SYSTEM

CARDS

WORKERS' COMPENSATION NEVADA LAW

COVERAGE VERIFICATION SERVICE

MEDICAL PROVIDERS

[Medical Providers Info Page](#)

[WCS Treating Panel of Physicians and Chiropractors](#)

[WCS Rating Panel Physicians](#)

INJURED WORKERS

[Injured Worker Info Page](#)

[Northern Complaint Form](#)

[Southern Complaint Form](#)

[Appeal Rights](#)

INSURERS / TPAs

[Insurers Info Page](#)

[COLA Info - PTID and Survivors Benefits \(Death\) Claims](#)

[Time Frames](#)

EMPLOYERS

[Employers Info Page](#)

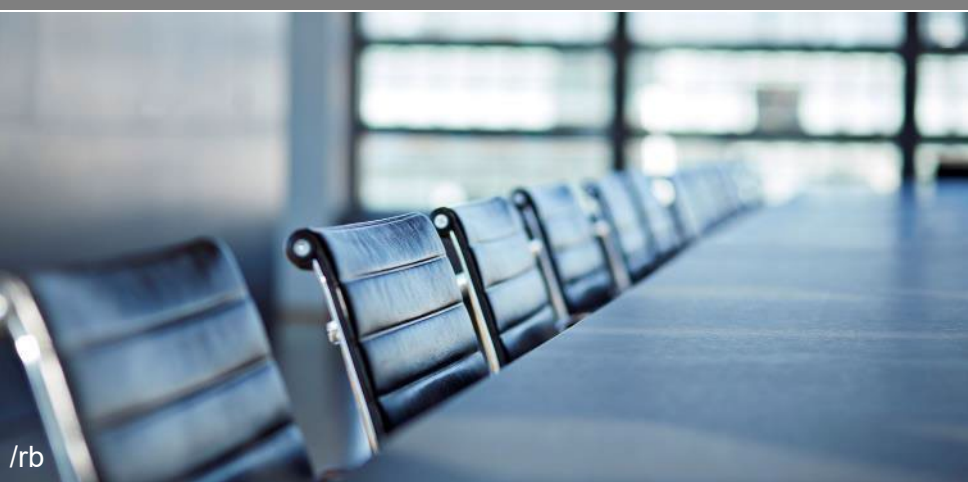
[Professional Employer Organizations \(PEOs\)](#)

[Posting Requirements](#)

WCS WEBSITE

<https://dir.nv.gov/WCS/Home/>

Please submit unanswered questions to WCSHelp@dir.nv.gov.



Thank you for attending today's training. Please check out the WCS website for additional training material.