

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

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What is the C-4 Form?

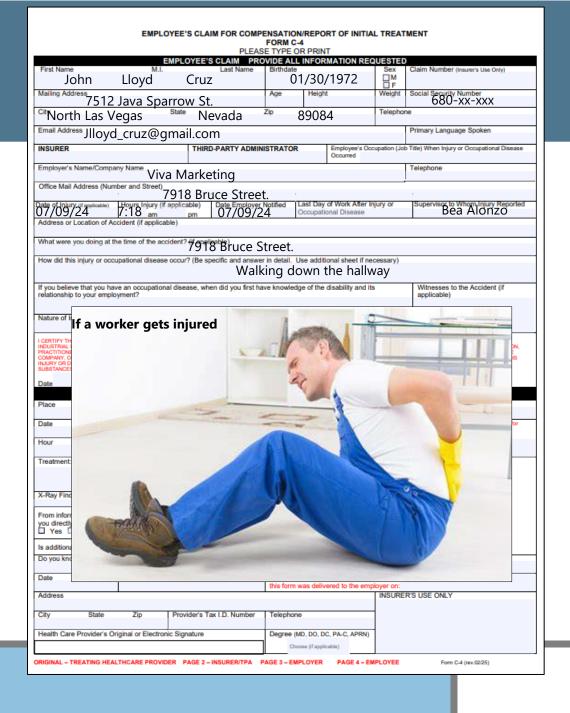


Employee's Claim for Compensation/ Report of Initial Treatment



C-4 FORM

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



The Injured Employee has

4() DAYS From the date of injury to seek medical treatment.

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

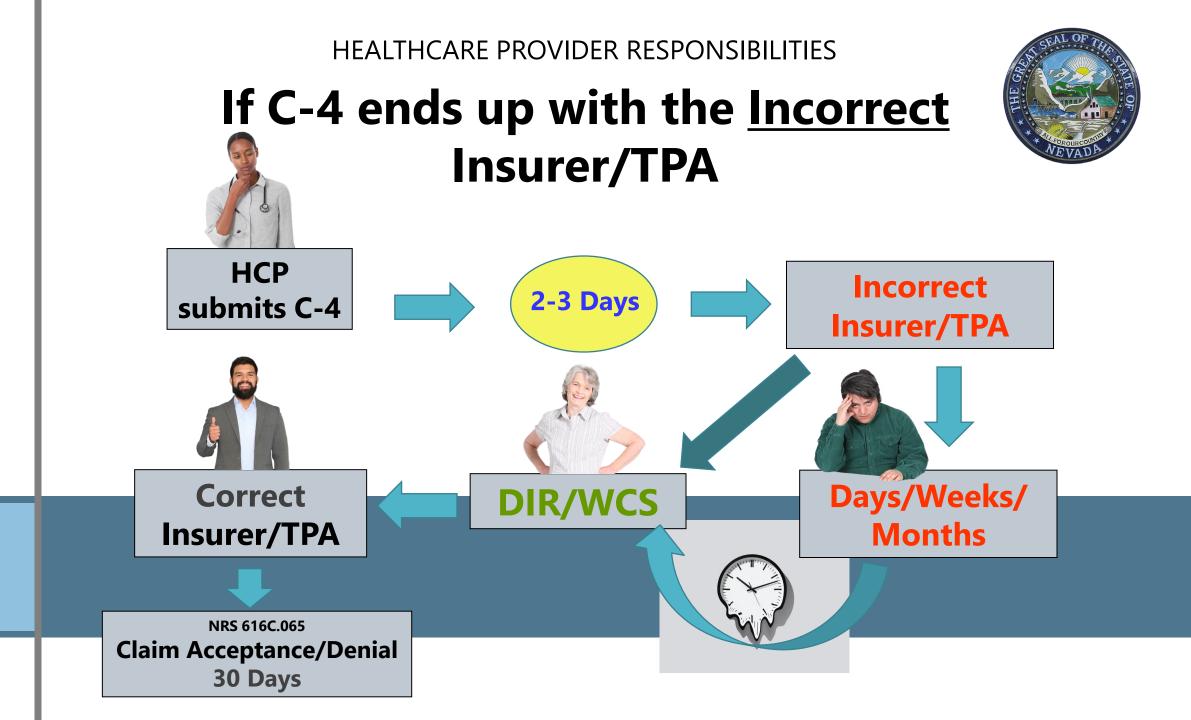


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City	State		Zip			Telephor	10 N	
Email Address							Primary Language Spoken	-
INSURER		THIRD-PARTY ADMIN	ISTRATO	R	Employee's Occ	spation (Job	Title) When Injury or Occupational Disease	
Employer's Name/Compa	w Maria				OCCUPIES .		Telephone	_
							Telephone .	
Office Mail Address (Numi	ber and Street)							
Date of Injury (Fappicable)	Hours Injury (if applica am	ble) Date Employer I pm	Notified	Last Day of	of Work After In nal Disease	ury or	Supervisor to Whom Injury Reported	
Address or Location of Ao	oident (if applicable)							
What were you doing at th	e time of the accident?	(f applicable)						-
How did this injury or occu	pational disease occur?	(Be specific and answer	rin detail.	Use additio	nal sheet if nec	essary)		
If you believe that you hav relationship to your emplo	e an occupational disea	se, when did you first ha	ve knowle	dge of the d	isability and its		Witnesses to the Accident (if applicable)	
Nature of Injury or Occupa			Part(s) o	of Body Injur	red or Affected			
CERTIFY THAT THE ABOVE IS NOUSTEIN, INDURANCE AND O REACTIONER OR ANY OTHER COMPANY, OR OTHER INSTITUT NUMPY OR DISEASE, EXCEPT IN SUBSTANCES, FOR WHICH IN	THUE AND COMMECT TO THE COUPATIONAL DISEASES AC PERSON, ANY HOSPITAL IN ION OR ORIGANIZATION TO D PORMATION RELATIVE TO D	BEST OF MY KNOWLEDGE AN TIS 1985 5154 TO 5160, MOLU CLUDING VETERAND ADMINIS RELEASE TO SACH OTHER, AN INGNOSIS, TREATMENT AND	ID THAT I HA ISINE, OR CO TRATION OF IT MEDICAL OR COUNTE	NEPROVIDED APTER STOP OCVERNMEN OR OTHER INF LNS FOR AD	THIS INFORMATION FIRES I HEREBY A TAL HOOPITAL, AN ORMATION, INCLU- S, PSYCHOLOGICA		TO GETAIN THE BENEFITS OF NEVADA'S ANY PHYTECIAL CHIROFRACTOR, SUBSION, DESVICE ORDANIZATION, ANY INSURANCE HTS PAD OR PATABLE, PENTINENT TO THIS N. ALCOHO, CHICONTOLIAD	
Date	Place	DATION, A PHOTOSTAT OF TH	S AUTHORIZ	Employee	's Original or c Signature			
	IS REPORT MUST	BE COMPLETED AND	MAILE	D WITHIN	3 WORKING	DAYS O	F TREATMENT	
Place		Na	me of Fac	ility				_
Date	Diagnosis and Description	of Injury or Occupational Disea	15 0 1	is there evided	nce that the injure	d employee	was under the influence of alcohol and/or the accident?	
Hour			ľ	3 No 🖸 Y	ived Bubbishide 38 ives. (If yes, piease	explain)	the accodent?	
Treatment.							work five days or more?	
Treatment.							to	
X-Ray Findings:							ele of 🔲 full duty 🗖 modified duty	
From information given by you directly connect this in Yes No	the employee, together jury or occupational dis	with medical evidence, o ease as job incurred?		r mooned out	ty, specify any lim	200151460	raone	
Is additional medical care			-					
Do you know of any previo	us injury or disease oor	tributing to this condition	or occup	ational disea	ise? 🔲 Yes	UN6 (Explain if yes)	-
Date	Print Health Care Pro	vider's Name	oertity:	that the emp	ployer's copy of			
Address			this form	1 was delive	red to the empl		R'S USE ONLY	
			Teles					
		der's Tax I.D. Number	Telepho					
Health Care Provider's Or	ginal or Electronic Sign	ature		(ND, DO, DC	PA-C, APRN)			
RIGINAL - TREATING HEAL	THCARE PROVIDER PI	GE 2 - INSURER/TPA	405 1-5	MPLOYER	PAGE 4 - EM	PLOYEE	Fam 0-4 (#v.03.08)	

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

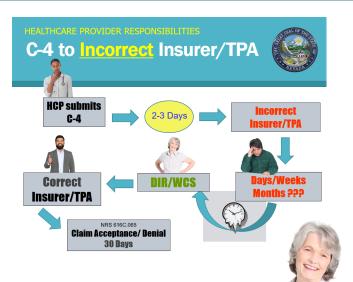


HEALTHCARE PROVIDER RESPONSIBILITIES Send C-4 to Correct Insurer/TPA



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.



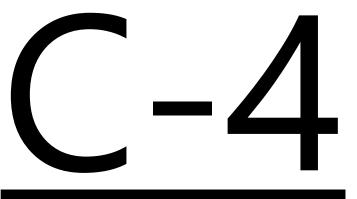


MEDICAL UNIT

EMPLOYER COMPLIANCE UNIT

DIR/WCS/ECU

		DIEAS	FORM C-4				
	EMPL				ATION REC	UESTED	
First Name	M.I.	Last Name	Birthdate			Sex	Claim Number (Insurer's Use Only)
Mailing Address			Age	Height		Weight	Social Security Number
City	State	•	Zip			Telephor	ne
Email Address							Primary Language Spoken
INSURER		THIRD-PARTY ADMIN	ISTRATOR	1	Employee's Occ	upation (Joi	o Title) When Injury or Occupational Disea
Employer's Name/Compar	iy Name			0	Occurred		Telephone
Office Mail Address (Numb	ar and Streat)						
	Hours Injury (if applic	able) Date Employer		ant Day of	Work After In		Supervisor to Whom Injury Repor
Date of Injury (rapplicable)	am	pm			al Disease	jury or	Supervisor to whom injury Repor
Address or Linear of Ad	id ent if Do called	D WOI	RKE	ER	SE	СТ	ION
What were you doing at the	e time of the accident	? (if applicable)					
How did this injury or occu	pational disease occu	r? (Be specific and answe	r in detail. U	se addition	hal sheet if neo	cessary)	
If you believe that you have		ana uhan didumu fari ba	us kasulada	o of the st	cobility and 't		Witnesses to the Assistant Of
If you believe that you have relationship to your employ		ase, when did you first ha	we knowledg	e or the di	sability and its	,	Witnesses to the Accident (if applicable)
Nature of Injury or Occupa	tional Disease		Part/c) of 5	Body Iniura	ed or Affected		_
mature or mjury or Occupa	uonai DisedSe		r ant(s) of b	Judy injure	a or Arrected		
I CERTIFY THAT THE ABOVE IS T INDUSTRIAL INSURANCE AND OF PRACTITIONER OR ANY OTHER I COMPANY, OR OTHER INSTITUT INJURY OR DISEASE, EXCEPT IN	RUE AND CORRECT TO TH COUPATIONAL DISEASES / PERSON, ANY HOSPITAL, I ION OR ORGANIZATION TO FORMATION RELATIVE TO	HE BEST OF MY KNOWLEDGE A ACTS (NRS 515A TO 516D, INCL INCLUDING VETERANS ADMINIS) RELEASE TO EACH OTHER, AN DIAGNOSIS, TREATMENT AND	ND THAT I HAVE USIVE, OR CHAP TRATION OR GO NY MEDICAL OR IOR COUNSELIN	PROVIDED PTER 617 OF OVERNMENT OTHER INFO IG FOR AIDS.	THIS INFORMATI NRS). I HEREBY TAL HOSPITAL, AN DRMATION, INCLI PSYCHOLOGIC/	ON IN ORDES AUTHORIZE : NY MEDICAL UDING BENE AL CONDITIO	R TO OBTAIN THE BENEFITS OF NEVADA'S ANY PHYSICIAN, CHIROPRACTOR, SURGEOI SERVICE ORGANIZATION, ANY INSURANCE FITS PAID OR PAYABLE, PERTINENT TO THI NS. ALCOHOL OR CONTROLLED
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SUBSTANCES, FOR WHICH I MUS	IS REPORT MUST	BE COMPLETED AN	D MAILED	Ton SHALL B Employee's Electronic WITTHIN 4	Songinal or Signature	DAYS O	F TREATMENT
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TWO PARTS OF THE C-4 FORM

NOT THE HEALTH INSURANCE COMPANY!

TO BE COMPLETED BY THE INJURED EMPLOYEE Injured Employee Section

	EMPLOYEE	CLAIM FOR COMP			VITIAL TR	EATME	NT
			FORM C-4 E TYPE OF				
	EMPLO				REQUES	TED	
First Name	M.I.	Last Name	Birthdate		Se		aim Number (Insurer's Use Only)
John	Lloyd			01/30/19	72	F	
John Mailing Address	7512 Java Sp	narrow 2	Age 52	Height 5 10'	" Wei	ght So	cial Security Number
City Nort	Las Vegas State		Zip 8	9084		phone	
	loyd@gmail.com	<u>/</u>				Pri	imary Language Spoken
John_	<u>-</u> coya ©gman.com						
INJURER	ican Mutual		ISTRATOR urwick	Occurred		n (Job Title	e) When Injury or Occupational Disease
Employer's Name/Con	mpany Name	N 1 1:				Tel	lephone
	Urva M	larketing					
Office Mail Address (N	Number and Street)	7918 Bruce Sta	reet.				
Date of Injury (rapplicable	e) Hours Injury (if applica	ble) Date Employer	Notified L	ast Day of Work A	fter Injury o	r S	Supervisor to Whom Injury Reported
07/09/24	am/:18	pm 07/	09/24	ocupational Disea	ase		Bea Alenzo
Address or Location of	f Accident (if applicable)	7918 Bruc	CI I				-
			e Treet.				
What were you doing a	at the time of the accident?	(if applicable)	alking do	wn the halli	way		
	occupational disease occur?	(Be specific and answer	r in detail. U	e additional sheet	t if necessar	y)	
	Slip and fall						
	have an occupational disea	se, when did you first ha	ve knowledg	e of the disability a	and its		Witnesses to the Accident (if
relationship to your en	Slip and	fall					applicable)
Nature of Injury or Occ	cupational Disease		Part(s) of E	ody Injured or Aff	ected		
				Knee and s	back		
INDUSTRIAL INSURANCE A	E IS TRUE AND CORRECT TO THE ND OCCUPATIONAL DISEASES AC	TS (NRS 515A TO 515D, INCLU	SIVE OR CHAP	PROVIDED THIS INFO TER 617 OF NRS), I HE	EREBY AUTHO	BIZE ANY P	OBTAIN THE BENEFITS OF NEVADA'S PHYSICIAN, CHIROPRACTOR, SURGEON,
INJURY OR DISEASE, EXCE	EPT INFORMATION RELATIVE TO D	HAGNOSIS, TREATMENT AND/	OR COUNSELIN	G FOR AIDS, PSYCHO	N, INCLUDING E	BENEFITS P DITIONS, A	VICE ORGANIZATION, ANY INSURANCE PUID OR PAYABLE, PERTINENT TO THIS VICOHOL OR CONTROLLED
SUBSTANCES, FOR WHICH	I MUST GIVE SPECIFIC AUTHORIA	ATION, A PHOTOSTAT OF TH		on shall be as vali Employee's Origina	al or	SINUS:	tin
Date	Place			Electronic Signatu			~



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.

	EMPEOTEE 3 CE	AIMTORCOMPT	FORM C-4		RIOFINITIAL		
			E TYPE OF		-		
	EMPLOYEE			INFOR	MATION REQ		
First Name	M.I.	Last Name	Birthdate			Sex	Claim Number (Insurer's Use Only)
Mailing Address	Lloyd	Cruz		01/	/30/1972		
Mailing Address	25100 0	Oruz	Age	Heigh	t	Weight	Social Security Number
	<u>1512 Java Spa</u>	rrow St.	52		5'10"		680-xx-xxx
City North -	<u>1512 Java Spa</u> Las Vegas ^{State}	Nevada	Zip	89	084	Telephor	ne
Email Address	loud Camail.com						Primary Language Spoken
INSURER Amorica	loydCymail.com n Mutual TH	RD-PARTY ADMIN	ISTRATOR		Employee's Occu Occurred	upation (Joi	o Title) When Injury or Occupational Disease
Employer's Name/Compar	w Name	ð	WWWWK				Telephone
	Viva Mar	keting					
Office Mail Address (Numb	LOL IN	18 Bruce S	treet.				
Date of Injury (rapplicable)	Hours Injury (if applicable)	Date Employer	Notified La	ast Day	of Work After Inj	ury or	Supervisor to Whom Injury Reported
07/09/24	am <i>7:18</i> pm	07/	/09/24	ccupati	onal Disease		Bea Alonzo
Address or Location of Acc	cident (if applicable)	7918 Bru	vee Stree	t.			U
What were you doing at the	e time of the accident? (if ap	plicable)	alking a	lown.	the hallwa	y	
	pational disease occur? (Be						
I In	lip and fall						
If you believe that you have relationship to your employ	e an occupational disease, w /ment?	vhen did you first ha	ve knowledge	e of the	disability and its		Witnesses to the Accident (if applicable)
	Slip and fa	ll					
Nature of Injury or Occupa	tional Disease		Part(s) of B		ured or Affected	b	
	RUE AND CORRECT TO THE BEST CCUPATIONAL DISEASES ACTS (N PERSON, ANY HOSPITAL, INCLUDI ION OR ORGANIZATION TO RELEA FORMATION RELATIVE TO DIAGNS 31 GIVE SPECIFIC AUTHORIZATION	SE TO EACH OTHER, AN DSIS, TREATMENT AND/	TRATION OR GO	PROVIDE TER 617 (VERNME OTHER IN G FOR AI	ED THIS INFORMATIC DF NRS). I HEREBY A INTAL HOSPITAL, AN IFORMATION, INCLU DS, PSYCHOLOGICA L BE AS VALID AS TH	N IN ORDER	R TO OBTAIN THE RENEFITS OF NEVADA'S ANY PHYBICIAN, CHIROPRACTOR, SURGEON, SERVICE ORIANIZATION, ANY INSURANCE FITS PAID OF PAI ABLE, FERTINGHT TO THIS NS, ALCONTOR CONTROLLED
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Date	Place			Electro	nic Signature		

ENDLOYEE'S CLAIM FOR COMPENSATION/DEPORT OF INITIAL TREATMENT

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 AN	D MAILED WITHIN 3 WORKING DAYS OF TREATMENT
4041 Spring Eine St.	ame of Facility <i>Poncentrate Plinic</i>
Date 07/09/2024 Diagnosis and Description of Injury or Occupational Dise	wher controlled substance at the time of the accident?
Hour 9:18 AM Strain on lower back and (R)	kneë
Treatment: Conservative home therapies such as	Have you advised the patient to remain off work five days or more?
Tylenol, NSAID, ice.	Yes Indicate dates: from to No If no, is the injured employee capable of: U full duty I modified duty
X-Ray Findings: None	If modified duty, specify any limitations/restrictions:
From information given by the employee, together with medical evidence, you directly connect this injury or occupational disease as job incurred?	can
Is additional medical care by a physician indicated? Yes No Do you know of any previous injury or disease contributing to this condition	n or occupational disease? Ves No (Explain if yes)
Date 07/09/2024 Print Health Care Provider's Name	I certify that the employer's copy of this form was delivered to the employer on:
Address 4041 Spring Line St.	INSURER'S USE ONLY
City State Zip Provider's Tax I.D. Number N. Cas Areas A Provider's Tax I.D. Number 99-84512-72	Telephone ₇₀₂₋₆₈₄₋₅₂₁₃
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.08/23)

What HCPs may sign a C-4 Form?

- MD
- DO
- DC
- APRN
- PA

None Signature

TO BE COMPLETED BY THE TREATING PHYSICIAN

Healthcare Provider Section

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 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, <u>Toll Free</u> 1-888-333-1597, Web site: https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance (OCHA)/ E-mail: cha@govcha.nv.gov

D-2 Form

Brief Description of Rights and Benefits

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

(NRS 616C.095)

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.

				FORM C	OR PRIN			
	EMP	LOYEE'S	CLAIM PRO	VIDE AL	L INFOR	MATION REC	UESTED	
First Name	M.I.		Last Name	Birthdate	•		Sex M	Claim Number (Insurer's Use Only)
Mailing Address				Age	Heigh	ıt	Weight	Social Security Number
City	Sta	te		Zip			Telepho	ne
Email Address								Primary Language Spoken
INSURER		THIRE	D-PARTY ADMIN	ISTRATOR	2	Employee's Oct Occurred	upation (Joi	o Title) When Injury or Occupational Disease
Employer's Name/Compa	ny Name	-						Telephone
Office Mail Address (Num	ber and Street)							1
Date of Injury (rapplicable)	Hours Injury (if appli	cable) pm	Date Employer	Notified		of Work After In onal Disease	jury or	Supervisor to Whom Injury Reported
Address or Location of Ac		pin						I
What were you doing at th	e time of the acciden	t? (if appli	cable)					
How did this injury or occu	upational disease occ	ur? (Be sp	ecific and answe	r in detail.	Use addit	ional sheet if ne	cessary)	
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If you believe that you hav		ease, wh	en did you first ha	ve knowled	dge of the	disability and its		Witnesses to the Accident (if
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Nature of Injury or Occupa	ational Disease			Part(s) o	f Body Inii	ured or Affected		_
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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 CLA	IM FOR COMP	ENSATI		RT OF INITIA	L TREAT	MENT
				E TYPE	OR PRIN			
	EMPL	OYEE'	S CLAIM PRO			MATION REC		
First Name	M.I.		Last Name	Birthda	ite		Sex M DF	Claim Number (Insurer's Use Only)
Mailing Address				Age	Height		Weight	Social Security Number
City	State			Zip			Telephor	
Email Address								Primary Language Spoken
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Employer's Name/Compare	ny Name							Telephone
Office Mail Address (Num								
Date of Injury (rappicable)	Hours Injury (if applic	able) pm	Date Employer	Notified		of Work After In anal Disease	njury or	Supervisor to Whom Injury Reported
Address or Location of Ao		pin						1
What were you doing at th	e time of the accident?	? (if app	licable)					
How did this injury or occu	pational disease occu	? (Be s	pecific and answer	r in detail	. Use additi	onal sheet if ne	oessary)	
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Address							INSURE	R'S USE ONLY
City State	Zip Prov	ider's T	ax I.D. Number	Teleph	one			
Health Care Provider's Or	iginal or Electronic Sig	nature			e (MD, DO, DO Choose (if applic	ble -	1	

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.



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 <u>medunit@dir.nv.gov</u>.

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.
- If you cannot identify the correct insurer or TPA, use the Coverage Verification Service (CVS) on the WCS website: <u>http://dir.nv.gov/WCS/home/</u>.
- 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.
- 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.

		PLEAS	FORM C-		г	L TREAT	
	EMPL	OYEE'S CLAIM PRO				UESTEI)
First Name	M.I.	Last Name	Birthdate			Sex M F	Claim Number (Insure's Use Only)
Mailing Address			Age	Height		Weight	Social Security Number
City	State		Zip			Telepho	ne
Email Address							Primary Language Spoken
INSURER		THIRD-PARTY ADMIN	ISTRATOR		Employee's Oct Occurred	upation (Jo	b Title) When Injury or Occupational Disea
Employer's Name/Compa	any Name						Telephone
Office Mail Address (Nun	nber and Street)						1
Date of Injury (Fapplicable)	Hours Injury (if applic am	able) Date Employer pm			of Work After Ir nal Disease	ijury or	Supervisor to Whom Injury Repor
Address or Location of A	ccident (if applicable)						
What were you doing at t	he time of the accident?	(if applicable)					
How did this injury or occ	upational disease occur	? (Be specific and answe	r in detail. U	se additio	onal sheet if ne	cessary)	
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END OF C-4 TRAINING

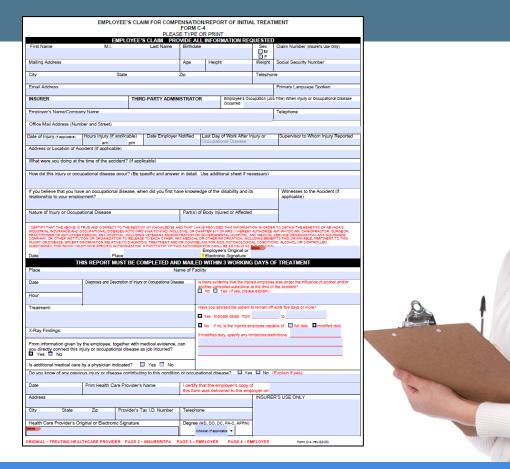
First part of training

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.



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.



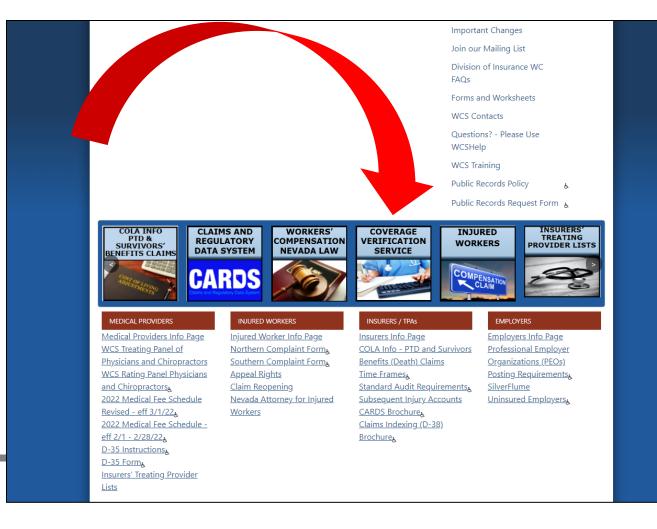
What is CVS?

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/



CVS Limitations



- 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 <u>not</u> 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



	EMPLOYEE'	S CLAIM FOR COMPE	FORM	C-4		L TREAT	MENT
	END:			OR PRIN			
First Name	ML	DYEE'S CLAIM PRO Last Name	Birthda		MATION REG	Sex	Claim Number (Insurer's Use Only)
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Mailing Address			Age	Height		Weight	Social Security Number
City	State	:	Zip			Telephor	ne
Email Address							Primary Language Spoken
INSURER		THIRD-PARTY ADMIN	ISTRATO	R	Employee's Oct Occurred	supation (Job	Title) When Injury or Occupational Disease
Employer's Name/Compar	ny Name						Telephone
Office Mail Address (Num	ber and Street)						
Date of Injury (f applicable)	Hours Injury (if applica am	able) Date Employer I	Notified		of Work After In mal Disease	ijury or	Supervisor to Whom Injury Reported
Address or Location of Acc							
What were you doing at th	e time of the accident?	(if applicable)					
How did this injury or occu	pational disease occur	? (Be specific and answer	in detail.	Use additi	onal sheet if ne	cessarv)	
						,,,,	
If you believe that you hav relationship to your employ		ase, when did you first ha	ve knowle	edge of the	disability and its	5	Witnesses to the Accident (if applicable)
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INDUSTRIAL INSURANCE AND O PRACTITIONER OR ANY OTHER COMPANY, OR OTHER INSTITUT	CCUPATIONAL DISEASES A PERSON, ANY HOSPITAL, IN TION OR ORGANIZATION TO	CTS (NRS 616A TO 616D, INCLU ICLUDING VETERANS ADMINIS' RELEASE TO EACH OTHER, AN	ISIVE, OR C TRATION O IY MEDICAL	HAPTER 617 C R GOVERNME OR OTHER IN	YF NRS). I HEREBY NTAL HOSPITAL, A FORMATION, INCL	AUTHORIZE / NY MEDICAL UDING BENER	R TO OBTAIN THE BENEFITS OF NEVADA'S ANY PHYSICIAN, CHIROPRACTOR, SURGEON, SERVICE ORGANIZATION, ANY INSURANCE FITS PAID OR PAYABLE, PERTINENT TO THIS NG, ALCOHOL OR CONTROLLED
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		BE COMPLETED AND	MAILE			DAYS O	E TREATMENT
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Date	Diagnosis and Description	of Injury or Occupational Disea		another contr	nce that the injun olled substance a res (if yes, pleas	at the time of	e was under the influence of alcohol and/or the accident?
Hour							
Treatment					vised the patient t cate dates: from		work five days or more?
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X-Ray Findings:				If modified du	ity, specify any lin	nitations/rest	trictions:
From information given by you directly connect this in Yes No	the employee, togethe jury or occupational dis	r with medical evidence, o sease as job incurred?	ban				
Is additional medical care	by a physician indicate	d? 🔲 Yes 🗌 No					
Do you know of any previo	ous injury or disease co	ntributing to this condition	or occup	ational dise	ase? 🛛 Yes	i 🗆 No (Explain if yes)
Date	Print Health Care Pro	vider's Name			ployer's copy o ered to the emp		
Address							R'S USE ONLY
City State	Zip Provi	ider's Tax I.D. Number	Teleph	one			
Health Care Provider's Ori	iginal or Electronic Sign	ature	Degree	(MD, DO, DO	, PA-C, APRN)		
Min Cal			d	hoose (if applic	able 🔻		
ORIGINAL - TREATING HEAL	THCARE PROVIDER P	AGE 2 – INSURER/TPA P	AGE 3 - E	MPLOYER	PAGE 4 - EN	PLOYEE	Form C-4 (rev.02/25)



Steps for Obtaining Insurance Information

<u>Step 1</u> Ask the injured employee to verify the employer name, address and telephone number.

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



Coverage Verification Service



CVS Notice and Disclaimer Page

WC Nevada Division Of Industrial Relations

Accept the terms of use to begin your search

Purpose – No Scripting or Automatic Retrieval:

The purpose of this website and Workers Compensation Coverage Verification is to assist you in determining whether an employer has workers compensation insurance in the state. Workers Compensation Coverage Verification will provide the name of the insurer that workers compensation policy for a specific employer on a specific date. Please note that Workers Compensation Coverage Verification is being provided to you for your personal, non-commercial use only, solely to verify an employer's workers compensation insurance coverage. Workers Compensation Coverage Verification may not be used in any other manner or for any other purpose, except as identified herein. Scripted queries and automatic retrieval(s) is are expressly prohibited.

Limitation of Available Information:

✓ ACCEPT

If an employer query does not produce any result(s) this may not mean that the employer does not have insurance or is operating in violation of state law. Coverage information may not be available or complete for all employers due to limitations with the policy information. Employer queries should be specific. Open ended queries may not return any results. In the event of excessive queries, you may be prohibited from accessing the information provided under Workers Compensation Coverage Verification. You may not disable or otherwise work around any restrictions and limitations that may be a part of Workers Compensation Coverage Verification. Nou may not disable or otherwise work around any restrictions and limitations that may be a part of Workers Compensation Coverage Verification. Scripted queries and automatic retrieval(s) is/are expressly prohibited. By clicking "Accept", below, you affirm that you have read and understand the notices and disclaimers on this page.

DOLL

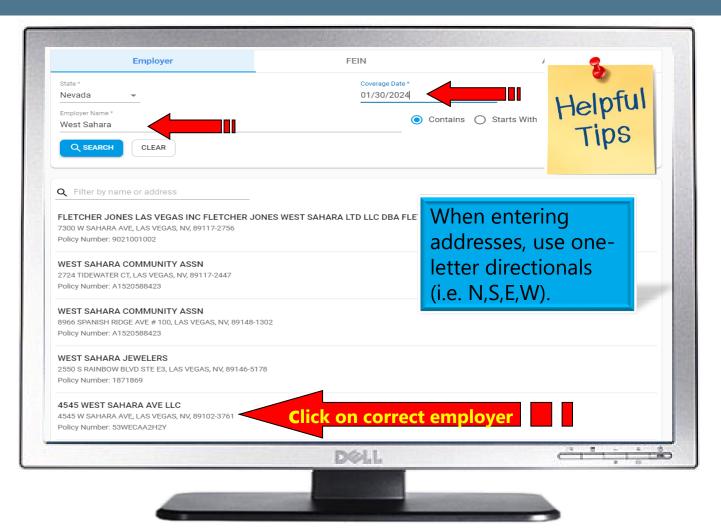
CVS

This site is protected by reCAPTCHA and the Google <u>Privacy Policy</u> and <u>Terms of Service</u> apply. **PRIVACY POLICY**

Date of Injury & Employer Information

Employer	FEIN	Address
State LESS IS Nevada MORE	Coverage Date * 03/03/2021	
Employer Name *	Co	ontains 🔘 Starts With
Q SEARCH CLEAR		
Limitation of Information		
The information provided on this web page is a segment of policy information rep compensation insurance carriers. Reporting delays, inaccuracies and omissions r employers are not included in the data. See "Self-Insured Search Tools" below. Search individual Self-Insured Employers using the Self-Insured Employer look- Nevada Division of Insurance Self-Insured Employer List	may affect the reliability of the coverage inforr Self-Insured Search Tools	
Search individual employers/members of a Self-Insured Association using the A Nevada Division of Insurance Associations of Self-Insured Employers List	ssociation Member look-up tool	
Nevada Division of Industrial Relations, Workers' Compensation Section		ther elpful Links
Nevada State Contractors Board License Search		
Nevada State Contractors Board License Search		
AAAada State Collifaciolis Dogla Fichilise Sharcii	DOLL	

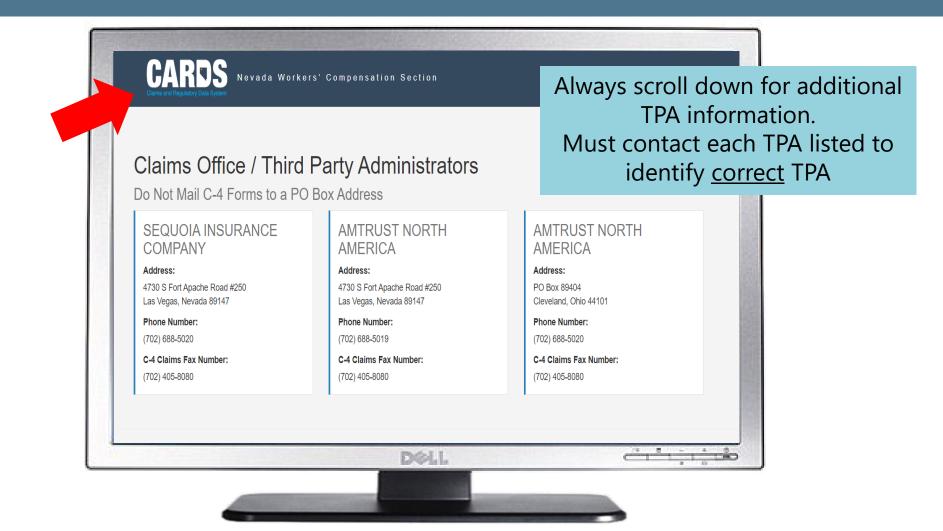
Policy Information



Policy/TPA Information

4545 WEST SAHARA AVE LLC		
Insurance Coverage Provider TWIN CITY FIRE INS CO	Policy Number 53WECAA2H2Y	Coverage Date 07/09/2024
CLICK HERE FOR CLAIM PROCESSING INFORMATION.	Click for TPA Info	
1 Employer Location(s)		
Q Filter by name or address		
4545 WEST SAHARA AVE LLC		
4545 W SAHARA AVE LAS VEGAS, NV, 89102-3761		

TPA Information/CARDS



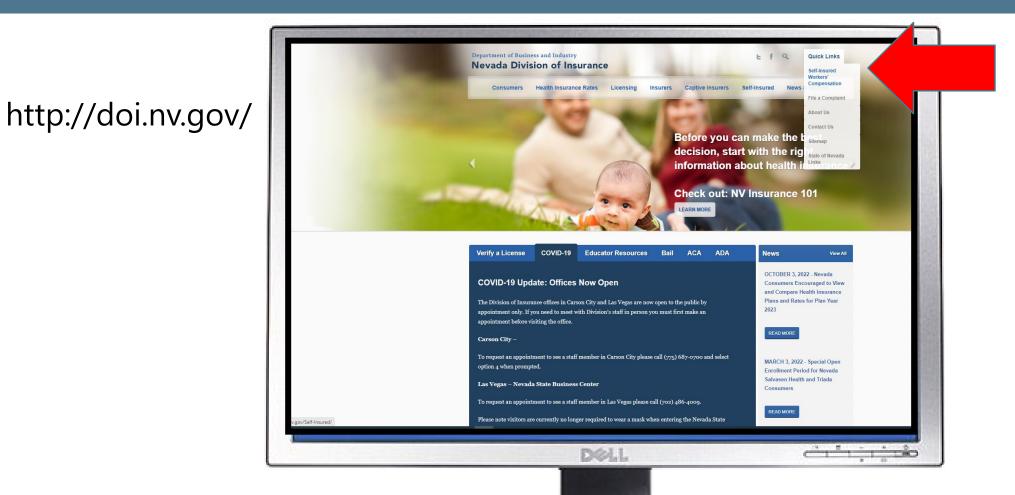
Steps for Obtaining Insurance Information

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

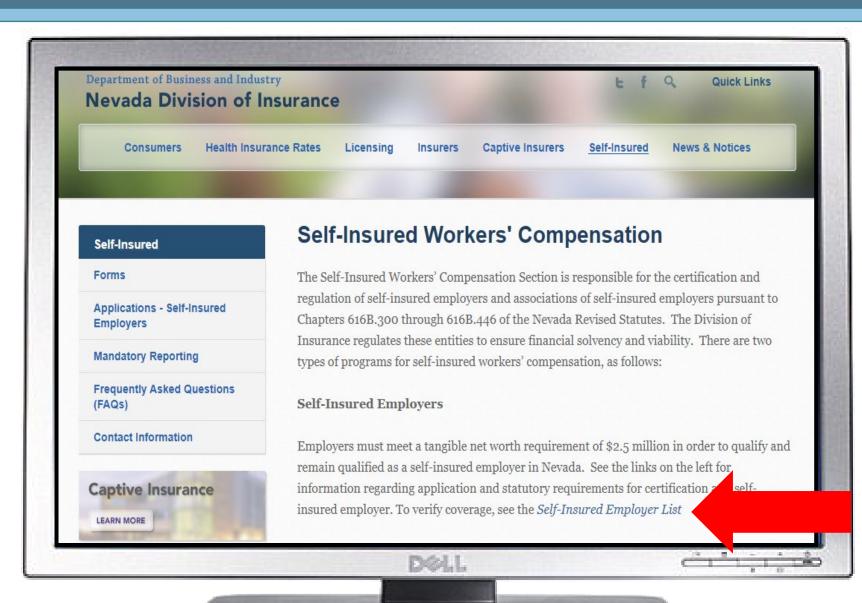
Step 3 Go to the Division of Insurance (DOI) website at <u>http://doi.nv.gov/</u>. Hover on the "Quick Links" tab to click "Self-Insured Workers' Compensation". Select either "Self-Insured Employer List" or "Association List."



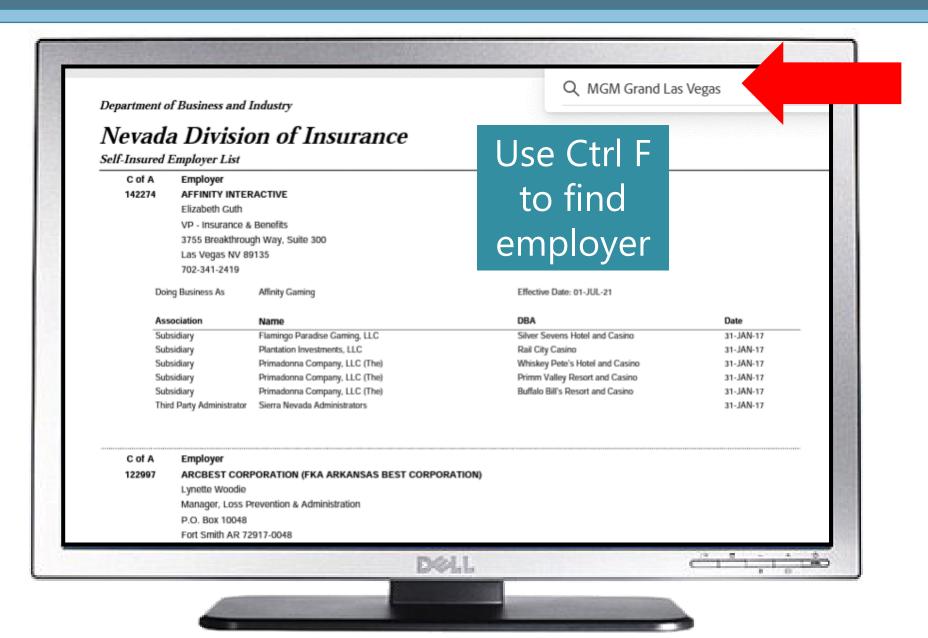
Self-Insured Employer Lookup: Nevada Division of Insurance



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 Workers' Compensation

The Self-Insured Workers' Compensation Section is responsible for the certification and regulation of self-insured employers and associations of self-insured employers pursuant to Chapters 616B.300 through 616B.446 of the Nevada Revised Statutes. The Division of Insurance regulates these entities to ensure financial solvency and viability. There are two types of programs for self-insured workers' compensation, as follows:

Self-Insured Employers

Self-Insured

Applications - Self-Insured

Frequently Asked Questions

Mandatory Reporting

Contact Information

Captive Insurance

File a Complaint

Verify a License

Forms

Employers

(FAQs)

LEARN MORE

LEARN MORE

LEARN MORE

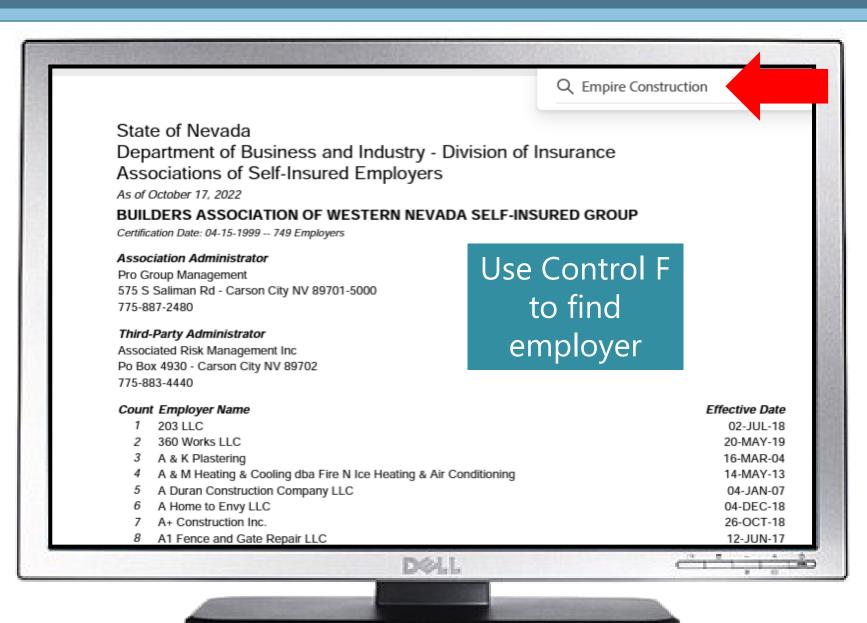
Employers must meet a tangible net worth requirement of \$2.5 million in order to qualify and remain qualified as a self-insured employer in Nevada. See the links on the left for information regarding application and statutory requirements for certification as a self-insured employer. To verify coverage, see the *Self-Insured Employer List*

Self-Insured Groups

There are currently eight self-insured groups in Nevada representing a variety of occupational groups. Employers may choose to become a member of one of these groups to comply with their statutory obligation to maintain workers' compensation coverage. See the *Association List* for a list of self-insured groups and their administrators. For information regarding the formation of a new group, please contact Maurice Fuller at *mfuller@doi.nv.gov* or (775) 687-0742.

Dell

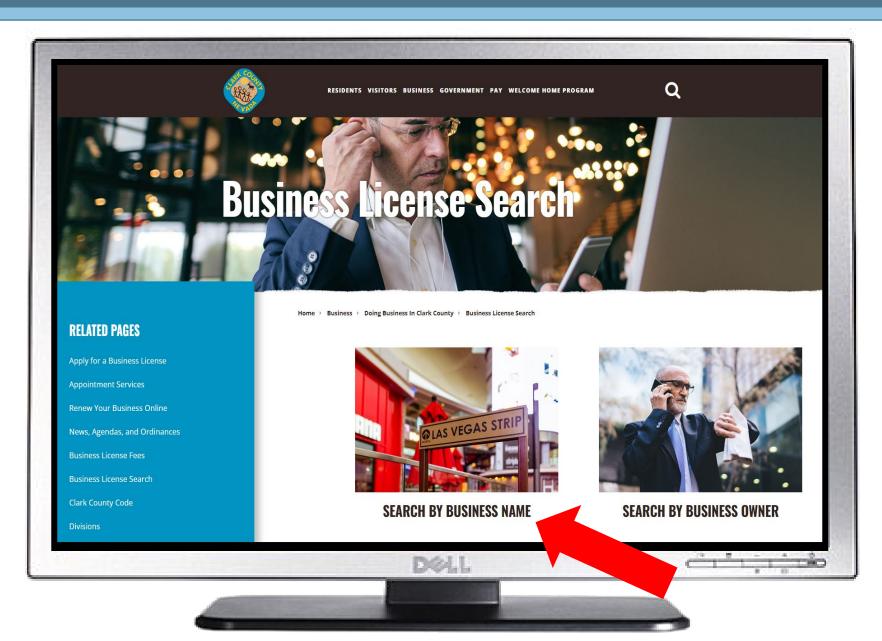
Self-Insured Association Member Lookup: Nevada Division of Insurance







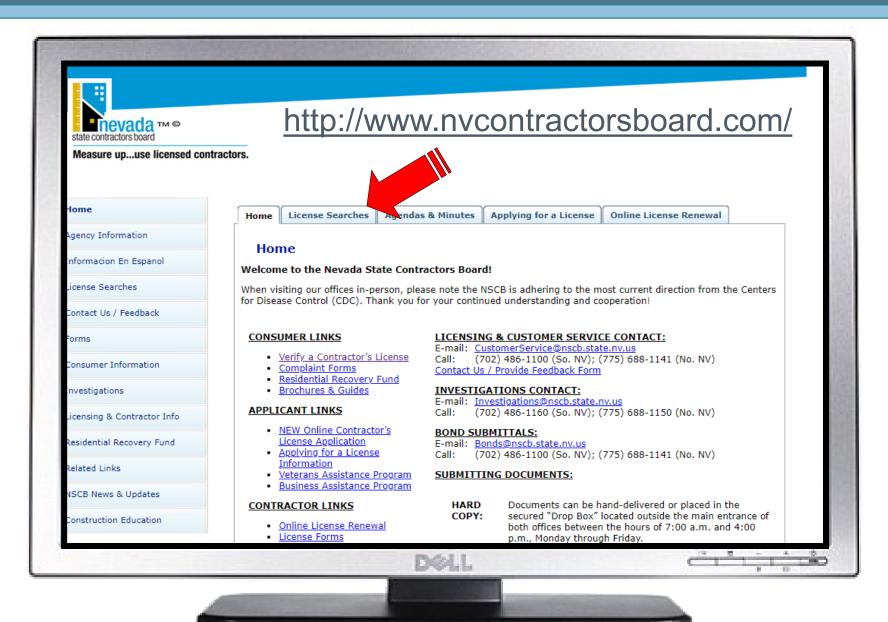
Business Name Lookup: Clark County Business License Search



Business Name Lookup: Clark County Business License Search

	Residents Visitors Business Government Pay News Contact Q Sec
Check Status of B	usiness License
action taken upon applications, please contact	epared as an informational service only and should not be relied upon as an official record of action on a business license. For official records and the city of Las Vegas Business License Division at (702) 229-6281.
Search Tips and Examples Business Cate Basic Search Advanced Search Download Business License Data	You may select any combination from this section Business Name * Partial match - see search tips:
	Address License/Permit Category Plus you may include any combination from this section Search licenses/permits by date License/Permit Status
	Search licenses/permits by date

Business Name Lookup: Nevada Contractors Board



Business Entity Search: SilverFlume



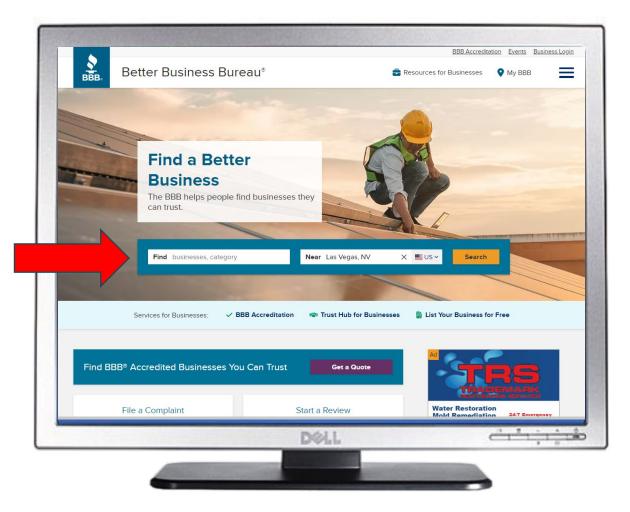
DBA Search: Clark County Fictitious Names

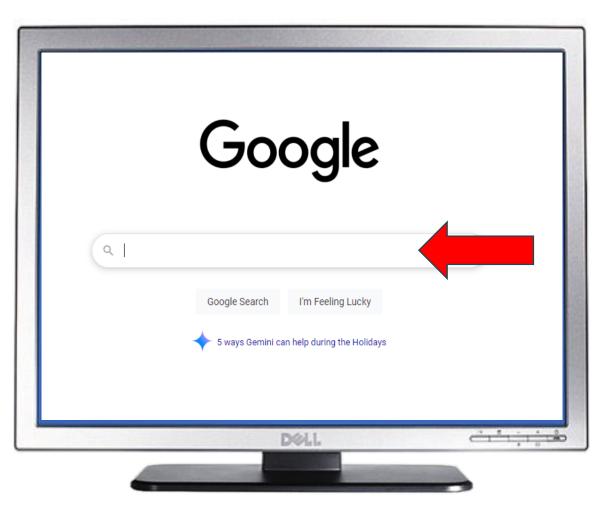
Home > FFN > Se	earch Type FFN By Name			
FFN Name	Search			
FFN Name				
Date Range	Last 6 Years	•		
From Date	12/20/2018	**		
To Date	12/20/2024	**		
Document Types	Select DocTypes			
	Document Type Groups			

Employer Phone Number Search: 411.com



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





Steps for Obtaining Insurance Information

<u>Step 4</u> 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.

<u>Step 6</u> 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



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/



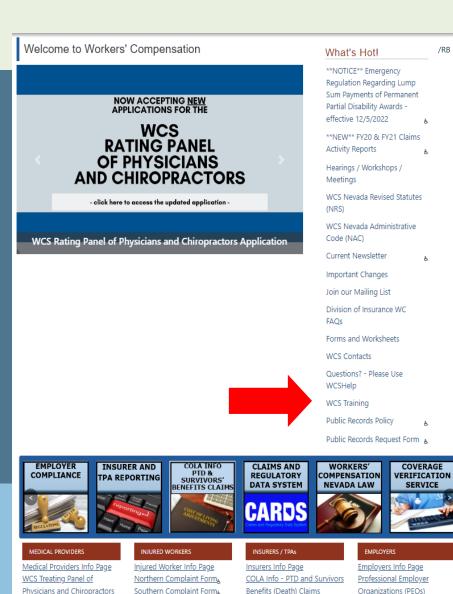
Medical Unit Contacts



Call (702) 486-9080

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





Time Frames,

Posting Requirements

WCS Rating Panel Physicians

Appeal Rights

WCS WEBSITE https://dir.nv.gov/WCS/Home/

Please submit unanswered questions to <u>WCSHelp@dir.nv.gov</u>.





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