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:

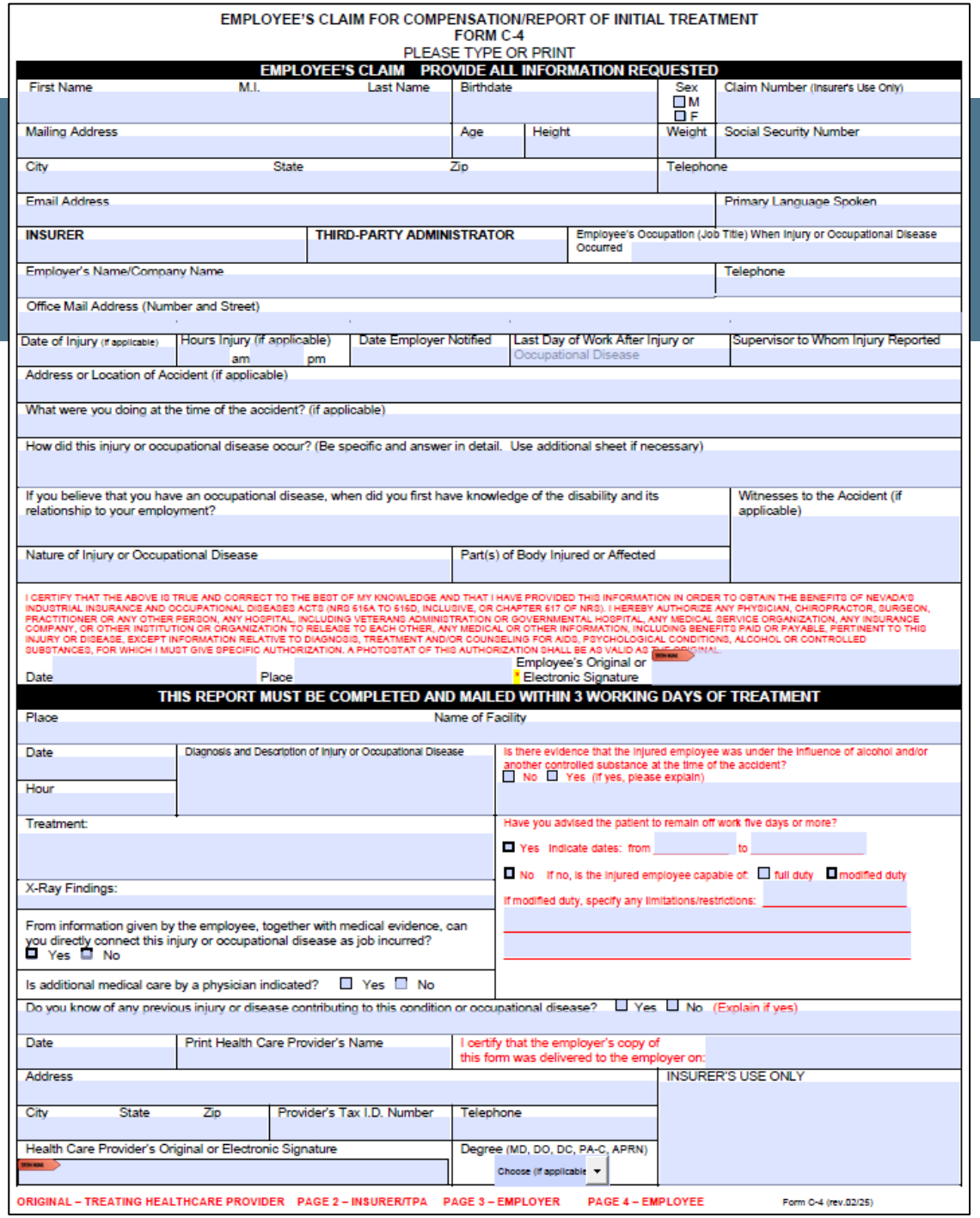
➢ Ensuring the timely and accurate delivery of workers' compensation benefits

➢ 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 ☐M ☐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

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? ☐ No ☐ Yes (if yes, please explain)

Hour

Treatment:

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from ____ to ____
☐ No If no, is the injured employee capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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)

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
PLEASE TYPE OR PRINT
EMPLOYEE'S CLAIM - PROVIDE ALL INFORMATION REQUESTED
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 | 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 or exposure | 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 WORKERS' COMPENSATION. I AUTHORIZE ANY PHYSICIAN, SURGEON, PRACTITIONER, OTHER PERSON, HOSPITAL, SANITARIUM OR MEDICAL SERVICE ORGANIZATION WHO HAS ATTENDED ME OR ANY OTHER PERSON, AND HOSPITAL, PUBLISHER, LIBRARIAN, ADMINISTRATOR OR GOVERNMENTAL AGENCY, NOT MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY OR OTHER ENTITY HERE OR FOR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE PERTAINED TO THIS INJURY OR OCCUPATIONAL DISEASE, EXCEPT PSYCHOTHERAPY NOTES, IN ORDER TO ADMINISTER THE CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
Date | Employee's Original or Electronic Signature
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT
Name of Facility
Date | Diagnosis and Description of Injury or Occupational Disease
Hour
Treatment:
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? Yes No
Is additional medical care by a physician indicated? Yes No
Do you know of any cause(s) a injury or disease contributing to this condition or occupational disease? Yes No (Explain if yes)
Date | Print Health Care Provider's Name
Address
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)
ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev 02/24)

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	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
John	Lloyd	Cruz	01/30/1972	☐M ☐F	

Mailing Address	Age	Height	Weight	Social Security Number
7512 Java Sparrow St.				680-xx-xxx

City	State	Zip	Telephone
North Las Vegas	Nevada	89084	

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)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
07/09/24	7:18 ☐am ☐pm	07/09/24		Bea Alonzo

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable): 7918 Bruce Street.

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
Walking down the hallway

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 I

I CERTIFY TH
INDUSTRIAL
PRACTITIONE
COMPANY. C
INJURY OR D
SUBSTANCES

Date

Place

Date

Hour

Treatment:

X-Ray Find

From infor
you directl
☐ Yes

Is additiona

Do you kn

Date

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)

The Injured Employee has

90

DAYS

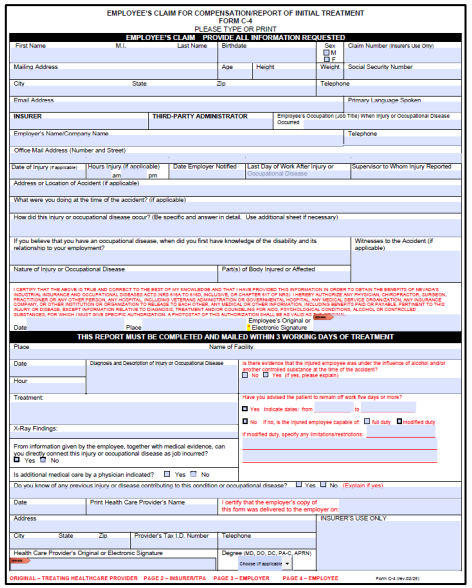
From the date of injury

to seek medical treatment.

NRS 616C.040

C-4 Submission by HCP

3 Working Days



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 ☐M ☐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 | 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, HOSPITAL, OTHER MEDICAL PROVIDER, INSURANCE COMPANY, EMPLOYER, WORKERS' COMPENSATION BOARD, OR ATTORNEY REPRESENTING ANY PARTY, 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 EACH / MUST SUB SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
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
Hour
Treatment:
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? ☐ Yes ☐ No
Is additional medical care by a physician indicated? ☐ Yes ☐ No
Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (If yes, please explain)
Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from to ☐ No If no, is the injured employee capable of ☐ full duty ☐ modified duty
If modified duty, specify any limitations/restrictions:
Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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)

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (Rev 03/09)

NRS 616C.065

Insurer/TPA Approve or Deny Claim

30 Days

HEALTHCARE PROVIDER RESPONSIBILITIES

Send C-4 to Correct Insurer/TPA

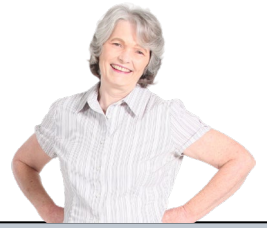
If C-4 ends up with the Incorrect Insurer/TPA

HCP submits C-4

2-3 Days

Incorrect Insurer/TPA

Days/Weeks/ Months



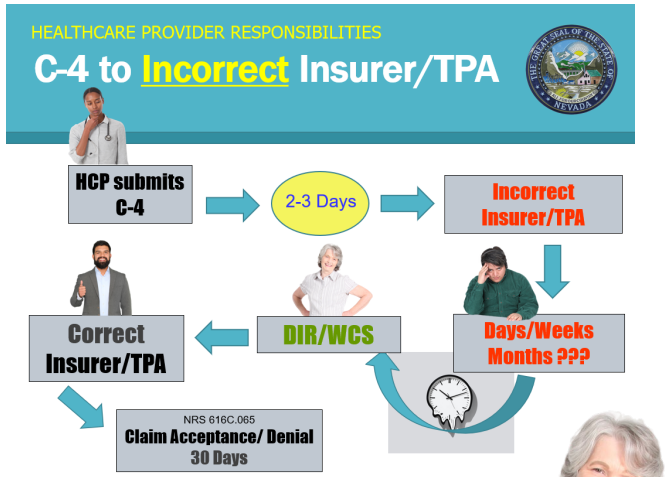
DIR/WCS

Correct Insurer/TPA

NRS 616C.065
Claim Acceptance/Denial
30 Days

HEALTHCARE PROVIDER RESPONSIBILITIES

If the WCS finds Employer without Workers' Compensation Coverage



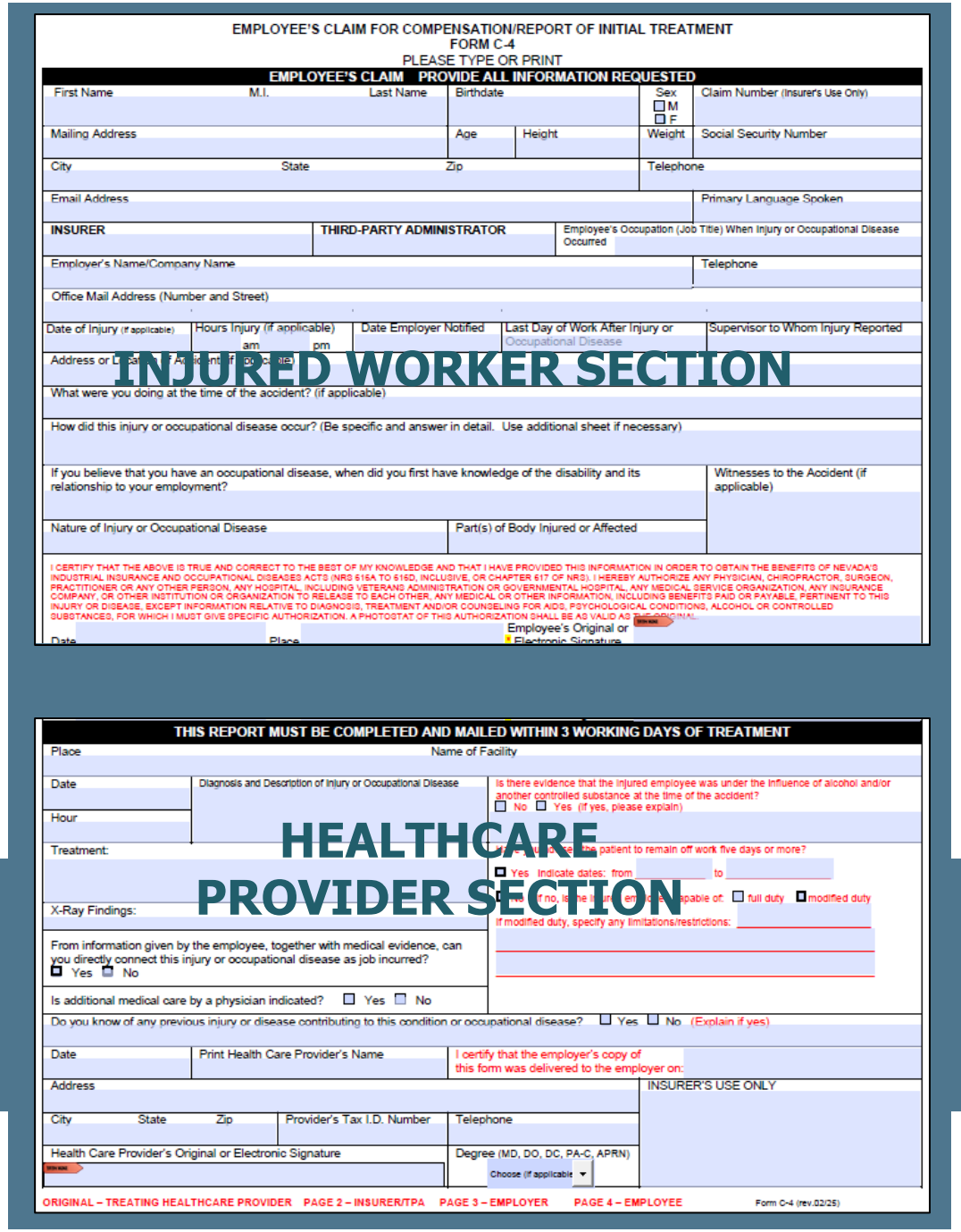
If the WCS is unable to find credible Workers' Compensation (WC) coverage for the employer of the injured employee, the case may be referred to the Employer Compliance Unit (ECU) for further investigation and compliance enforcement.

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 ☐M ☐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

Hour

Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (If yes, please explain)

Treatment:

Do you advise the patient to remain off work five days or more?
☐ Yes Indicate dates: from to
☐ No, is he able to perform work capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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 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	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
John	Lloyd	[illegible]	01/30/1972	☒ M ☐ F	

Mailing Address	Age	Height	Weight	Social Security Number
7512 Java Sparrow [illegible]	52	5'10"		680-xx-xxx

City	State	Zip	Telephone
North Las Vegas	Nevada	89084	

Email Address	Primary Language Spoken
John [illegible]loyd@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
01/09/24	am 7:18 pm	01/09/24		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? Slip and fall

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
	Knee and back

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

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

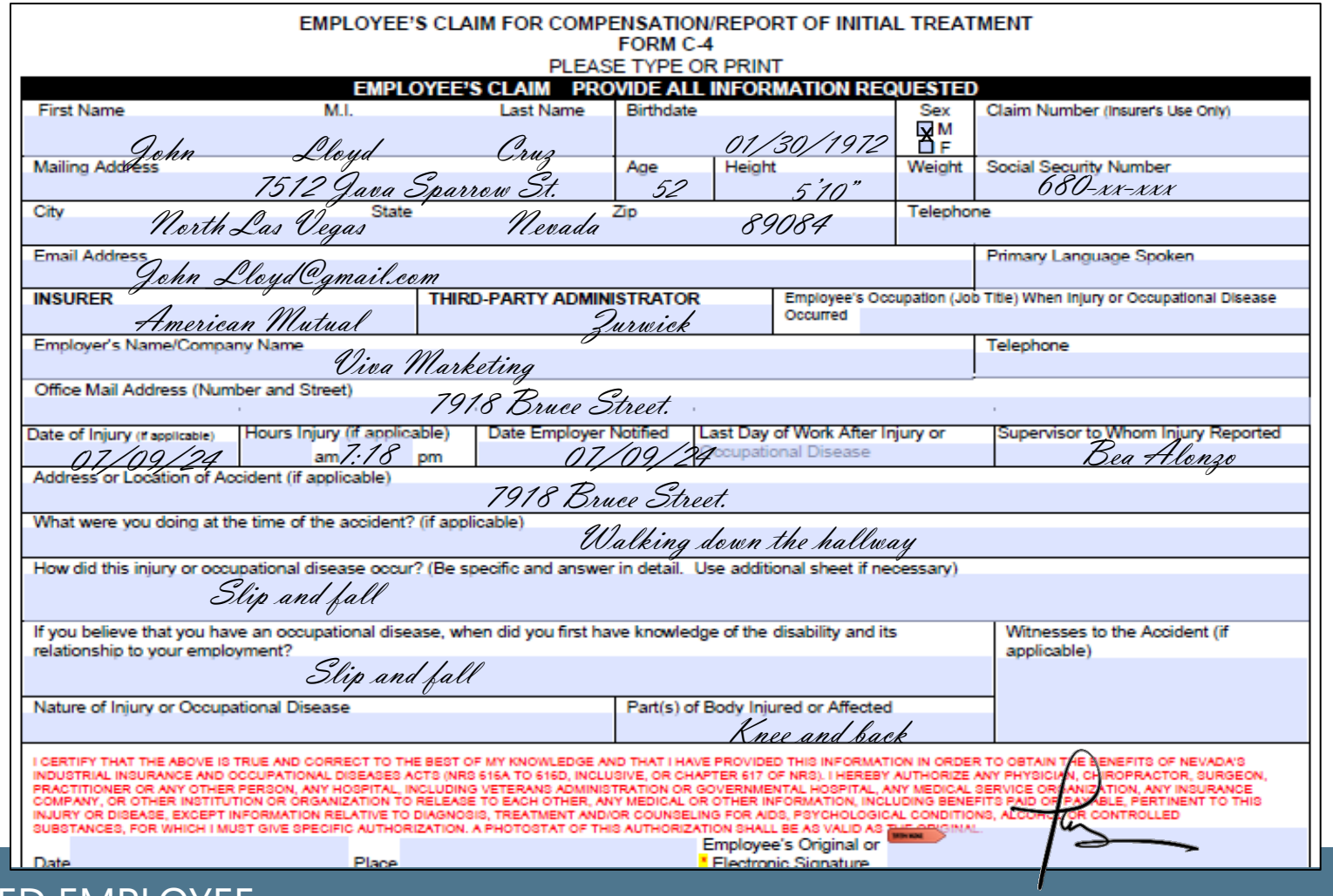
- Date, time, and location of accident
- Describe the incident in specific details

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 (Insurer's Use Only)
John	Lloyd	Cruz	01/30/1972	☒ M ☐ 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? Slip and fall

Witnesses to the Accident (if applicable):

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
	Knee and back

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

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: 4041 Spring Line St. | Name of Facility: Concentrate Clinic

Date: 07/09/2024 | Hour: 9:18 AM | Diagnosis and Description of Injury or Occupational Disease: Strain on lower back and (R) knee

Is there evidence that the injured employee was under the influence of alcohol and/or [illegible] controlled substance at the time of the accident? [illegible]s (if yes, please explain)

Treatment: Conservative home therapies such as Tylenol, NSAID, ice.

Have you advised the patient to remain off work five days or more?

☐ Yes Indicate dates: from _____ to _____

☑ No If no, is the injured employee capable of: ☑ full duty ☐ modified duty

If modified duty, specify any limitations/restrictions: _____

X-Ray Findings: none

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?

☑ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☑ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☑ No (Explain if yes)

Date: 07/09/2024 | Print Health Care Provider's Name: Dr. Pepper | 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: N. Las Vegas | State: NV | Zip | 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

TO BE COMPLETED BY THE TREATING PHYSICIAN

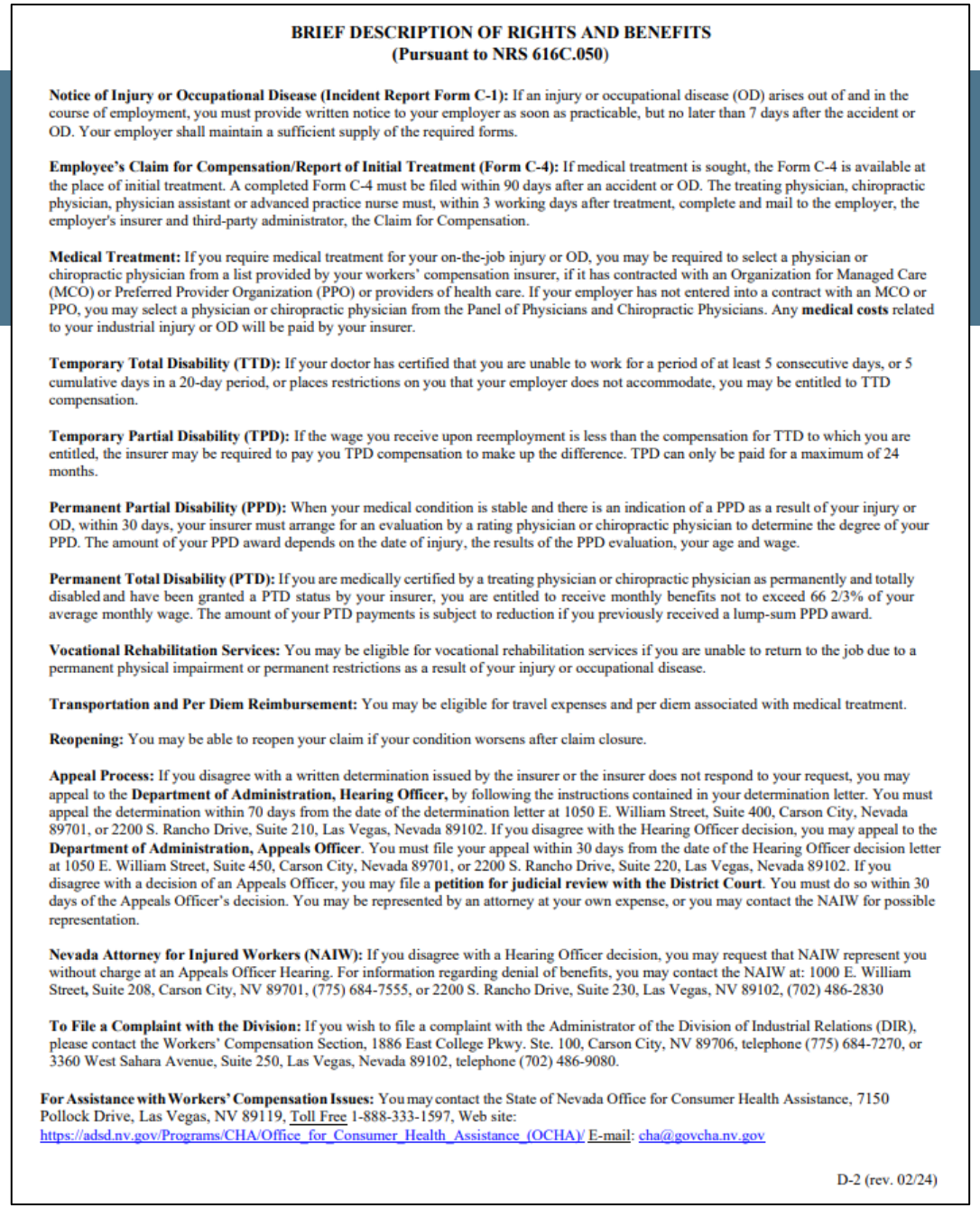
Healthcare Provider Section

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.

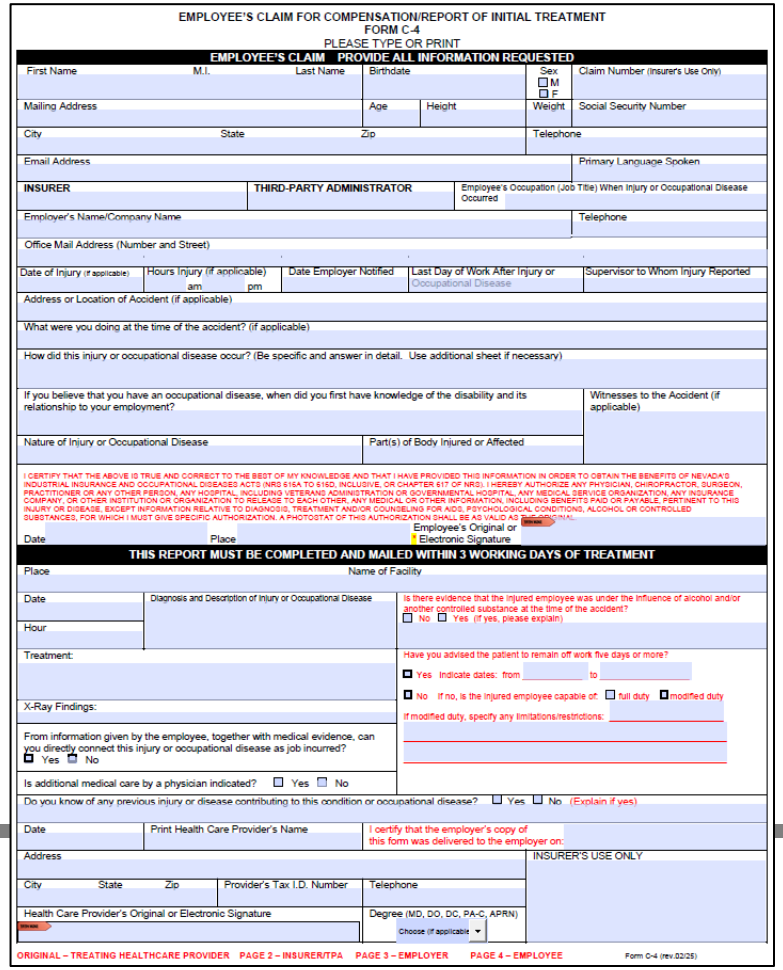
For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 7150 Pollock Drive, Las Vegas, NV 89119, Toll Free 1-888-333-1597, Web site: https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/ E-mail: cha@govcha.nv.gov

D-2 (rev. 02/24)

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 ☐M ☐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

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

Place | Name of Facility

Date | Hour | 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? ☐ No ☐ Yes (if yes, please explain)

Treatment: | Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from ____ to ____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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

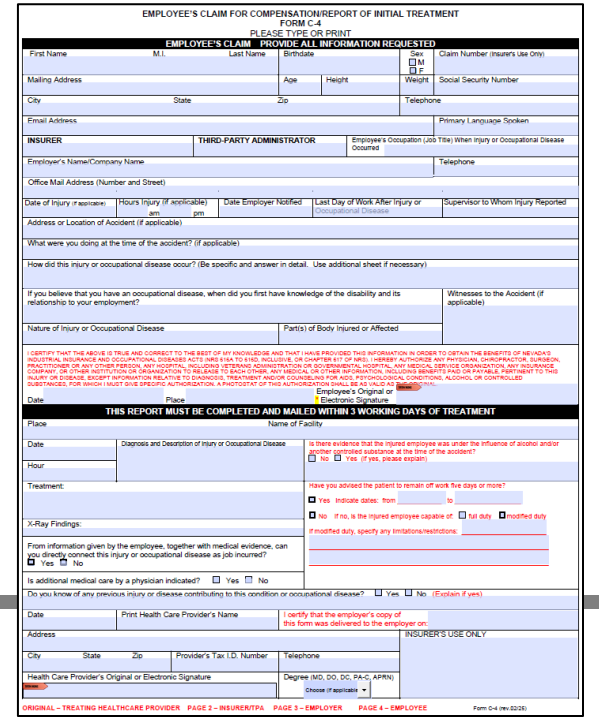
City | State | Zip | Provider's Tax I.D. Number | Telephone

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.02/26)

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

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED

First Name | M.I. | Last Name | Birthdate | Sex ☐M ☐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

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

Place | Name of Facility
Date | Hour | 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? ☐ No ☐ Yes (If yes, please explain)
Treatment:
X-Ray Findings:
Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from ____ to ____ ☐ No If no, is the injured employee capable of ☐ full duty ☐ modified duty
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? ☐ Yes ☐ No
Is additional medical care by a physician indicated? ☐ Yes ☐ No
Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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

Proof of Coverage (POC) Call:

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

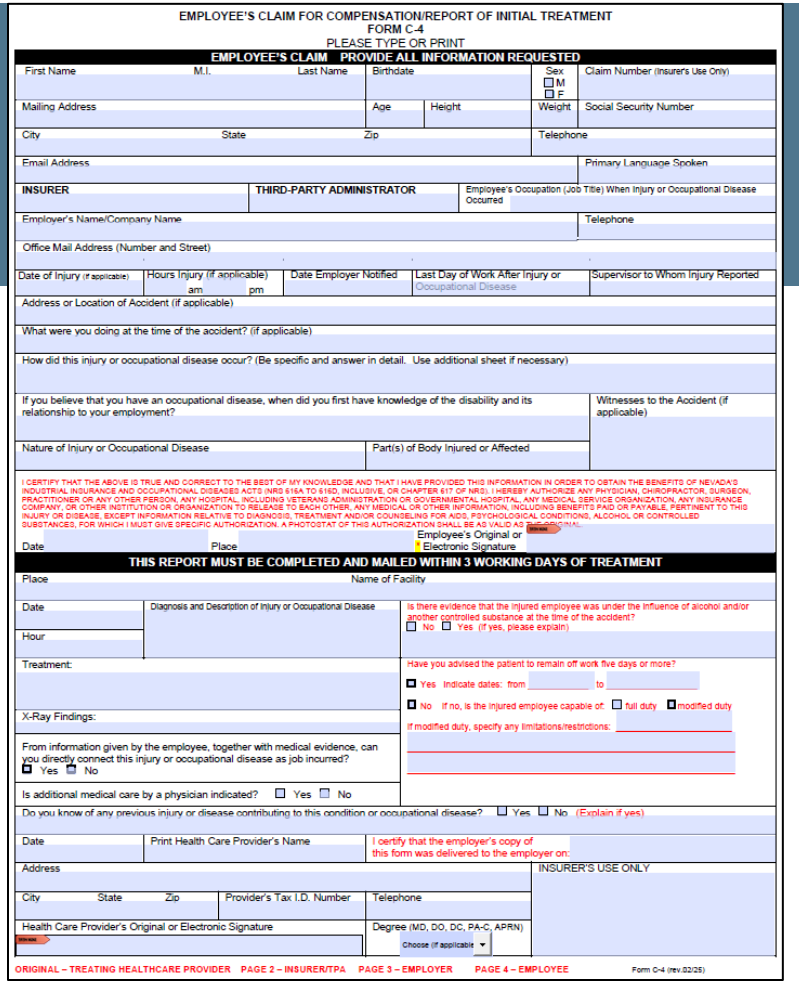
(702) 486-9080

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



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 ☐ M ☐ 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

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

Place | Name of Facility
Date | Hour | 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? ☐ No ☐ Yes (If yes, please explain)
Treatment:
Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from to ☐ No If no, is the injured employee capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No
Is additional medical care by a physician indicated? ☐ Yes ☐ No
Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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)

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

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.

END OF C-4 TRAINING

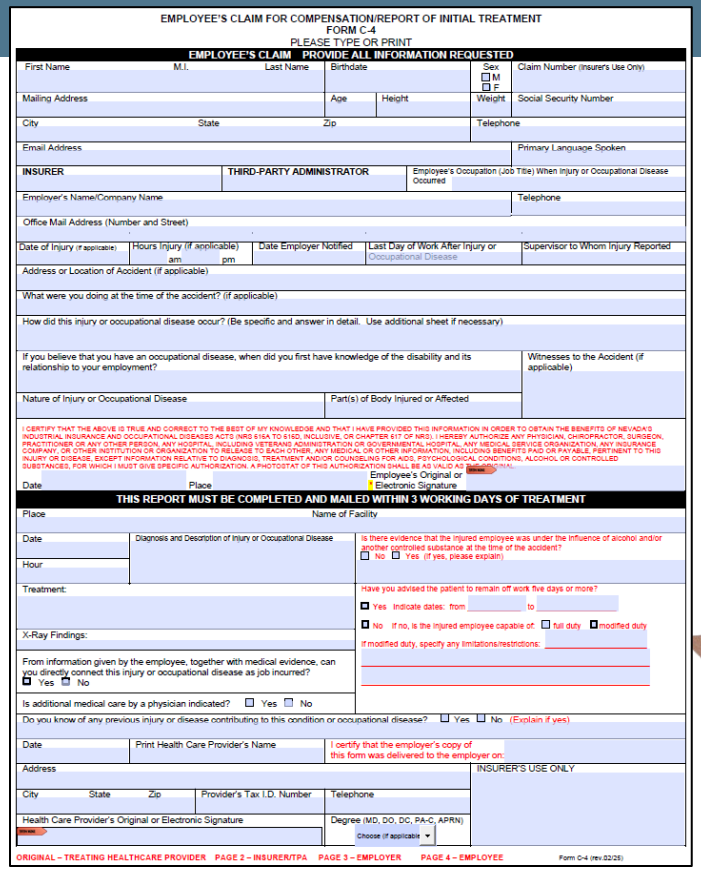
First part of training

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 ☐M ☐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

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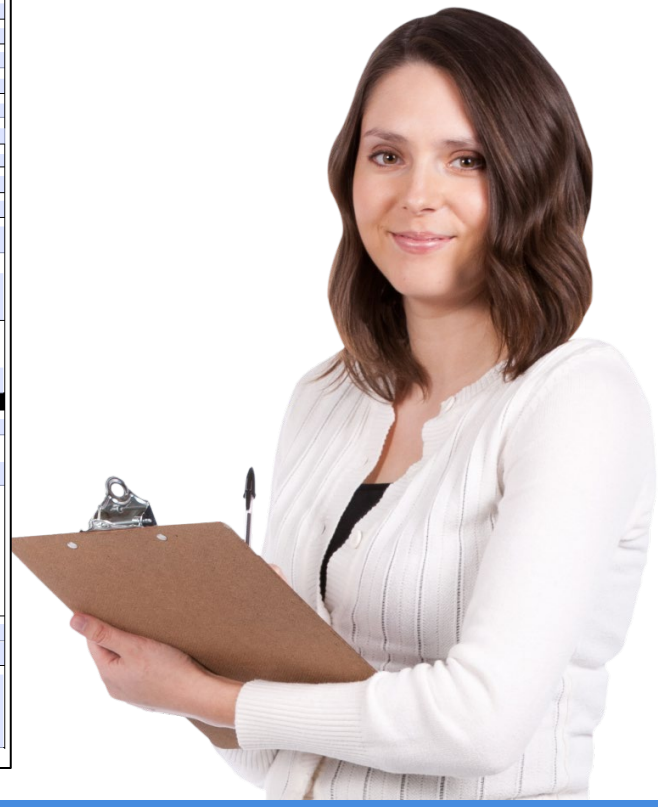
Date | Place | Employee's Original or Electronic Signature

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

Place | Name of Facility
Date / Hour | 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? ☐ No ☐ Yes (if yes, please explain)
Treatment: | Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from to ☐ No If no, is the injured employee capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No
Is additional medical care by a physician indicated? ☐ Yes ☐ No
Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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)

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.

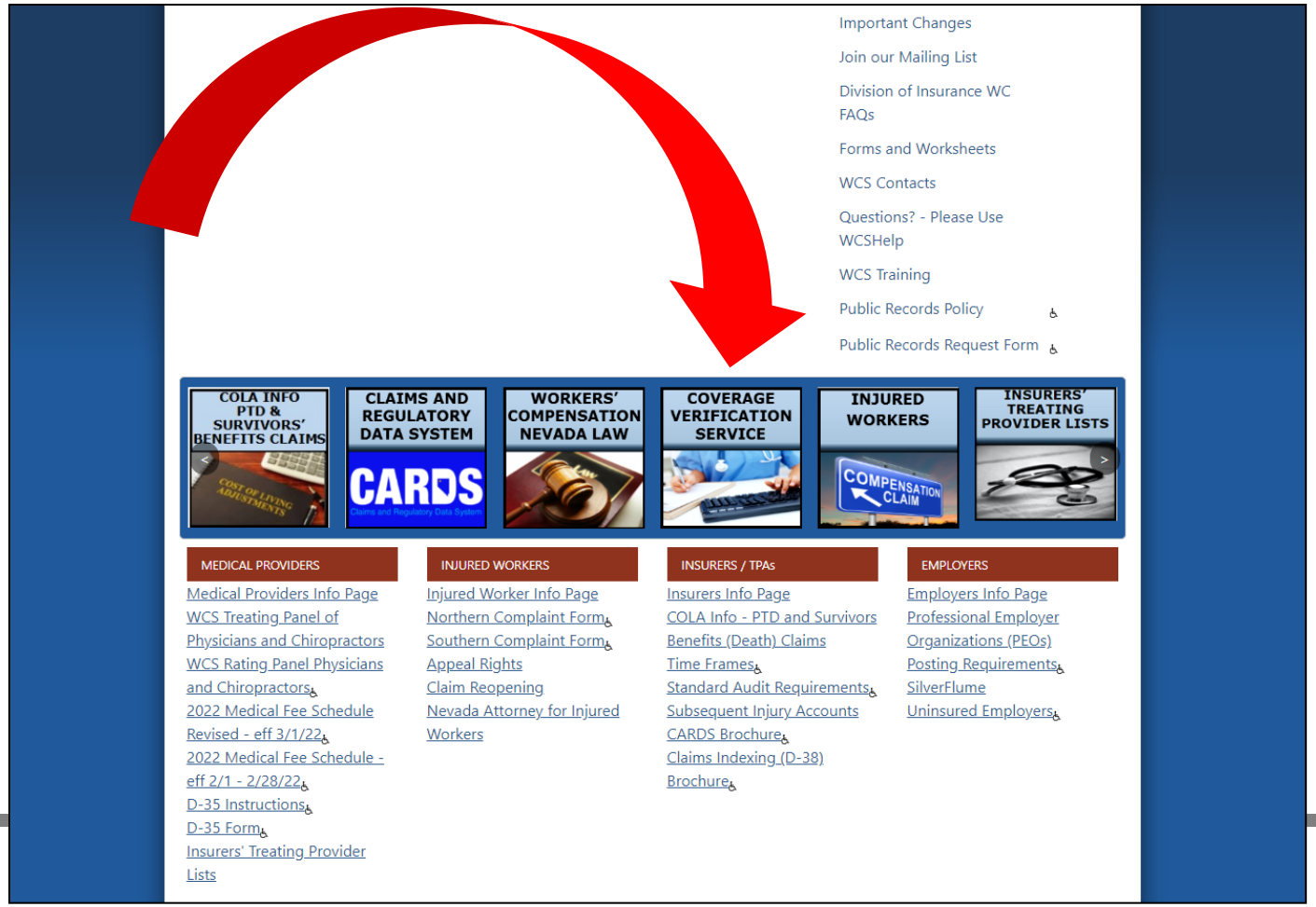
What is CVS?

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/



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 ☐M ☐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

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

Place | Name of Facility

Date | Hour | 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? ☐ No ☐ Yes (If yes, please explain)

Treatment:

Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from ____ to ____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ 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? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ 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)

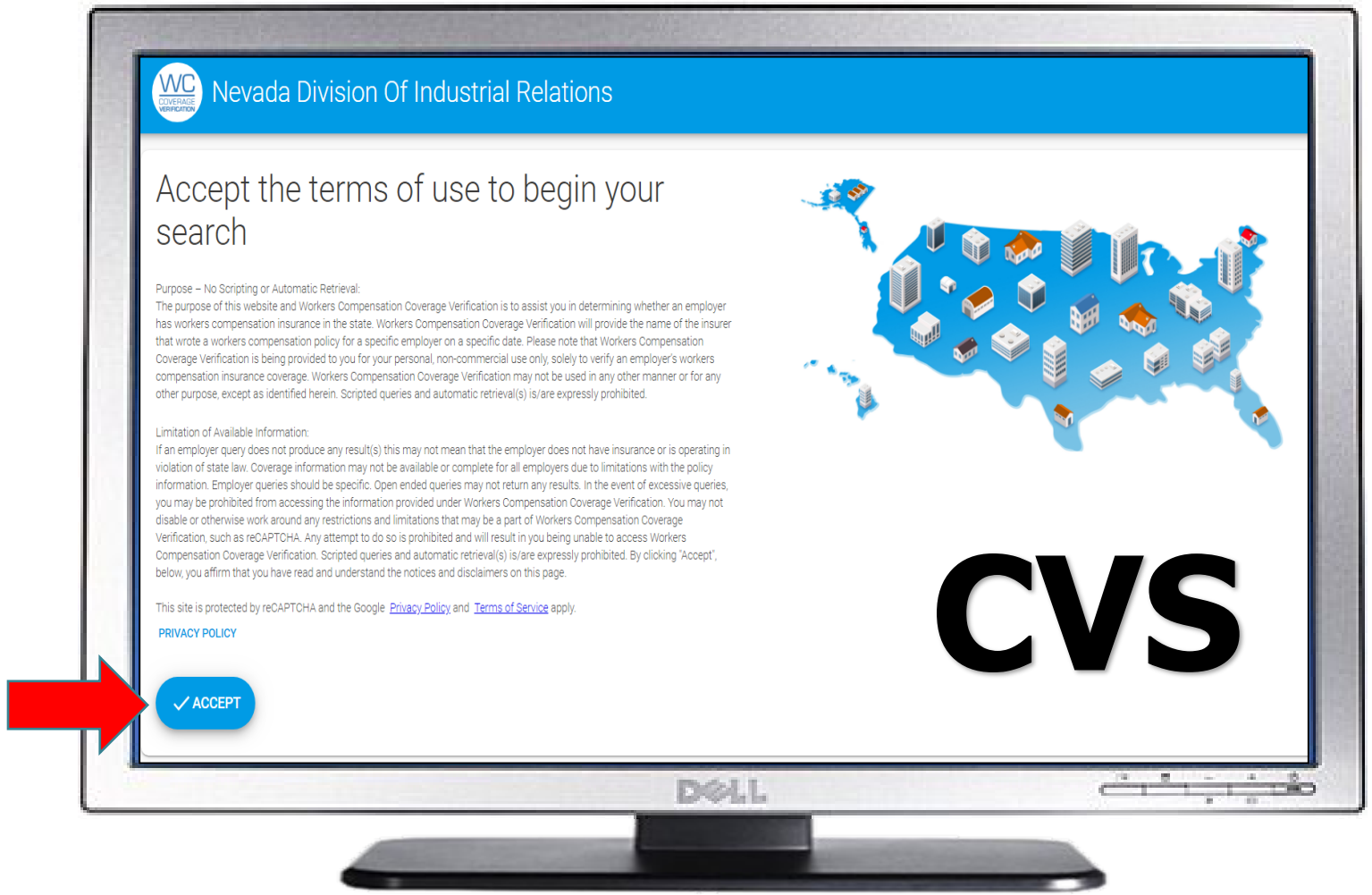
Steps for Obtaining Insurance Information

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

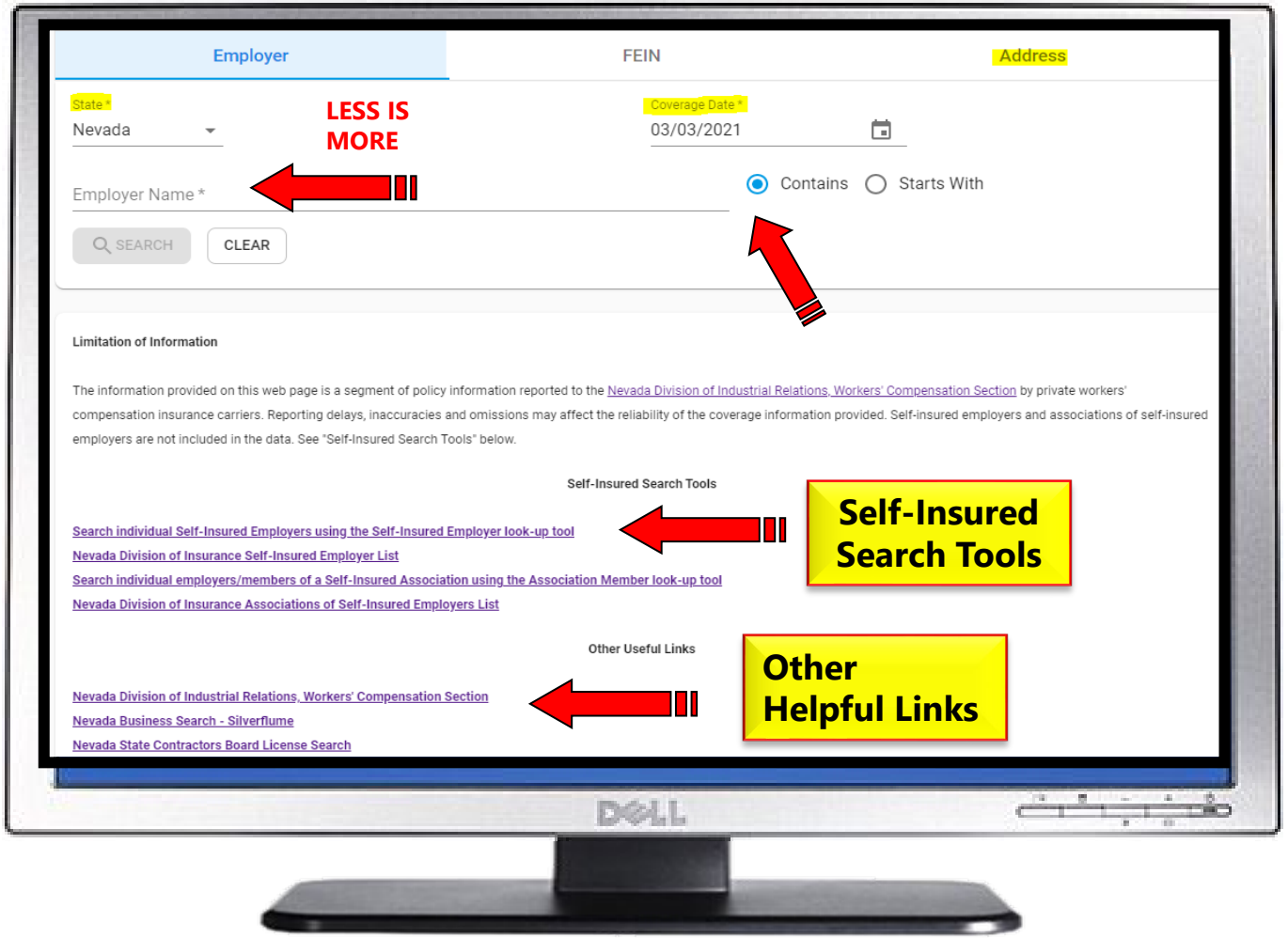
Step 2 Use CVS on the WCS website **http://dir.nv.gov/WCS/home/**.

Coverage Verification Service

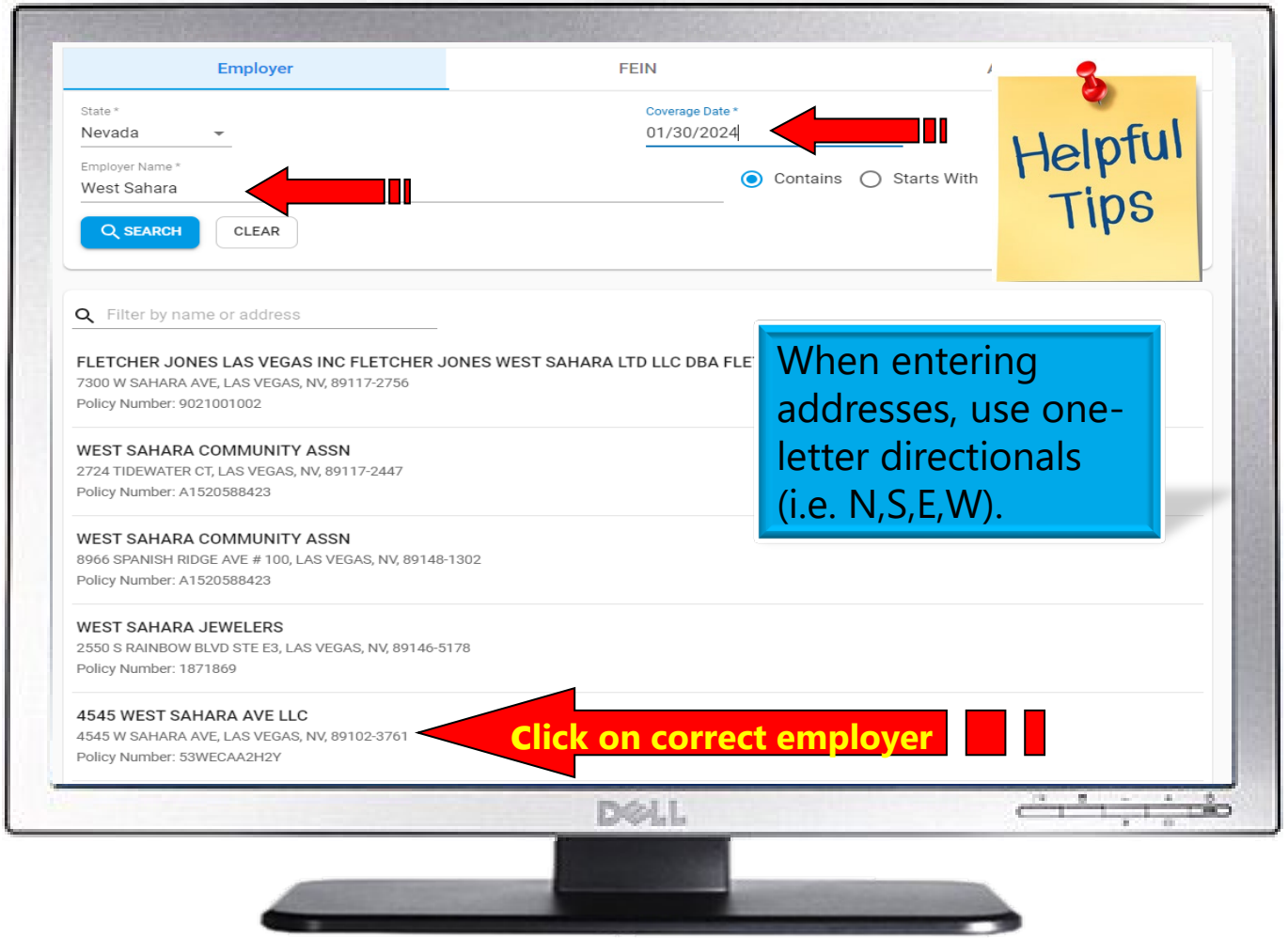
CVS Notice and Disclaimer Page



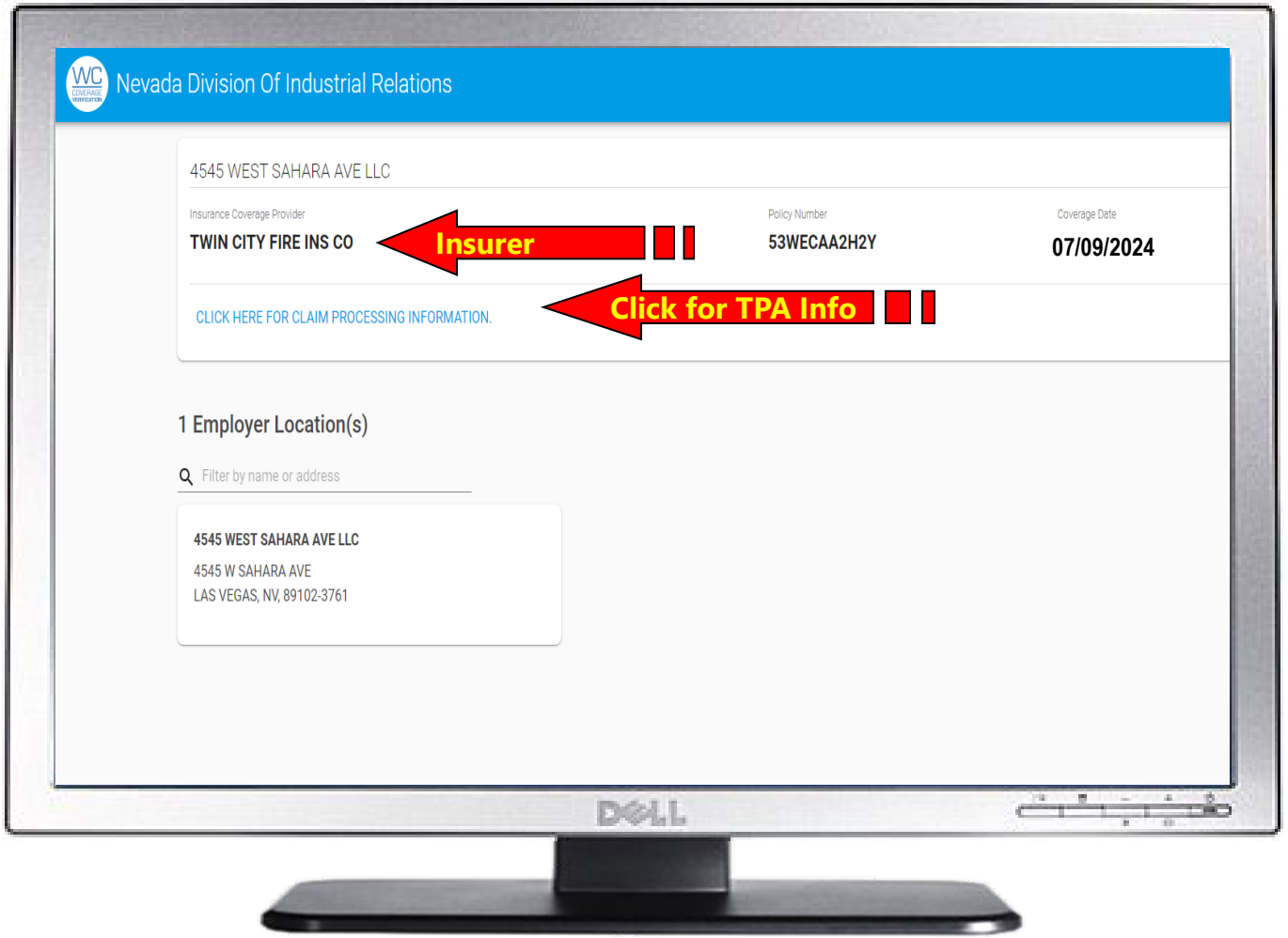
Date of Injury & Employer Information



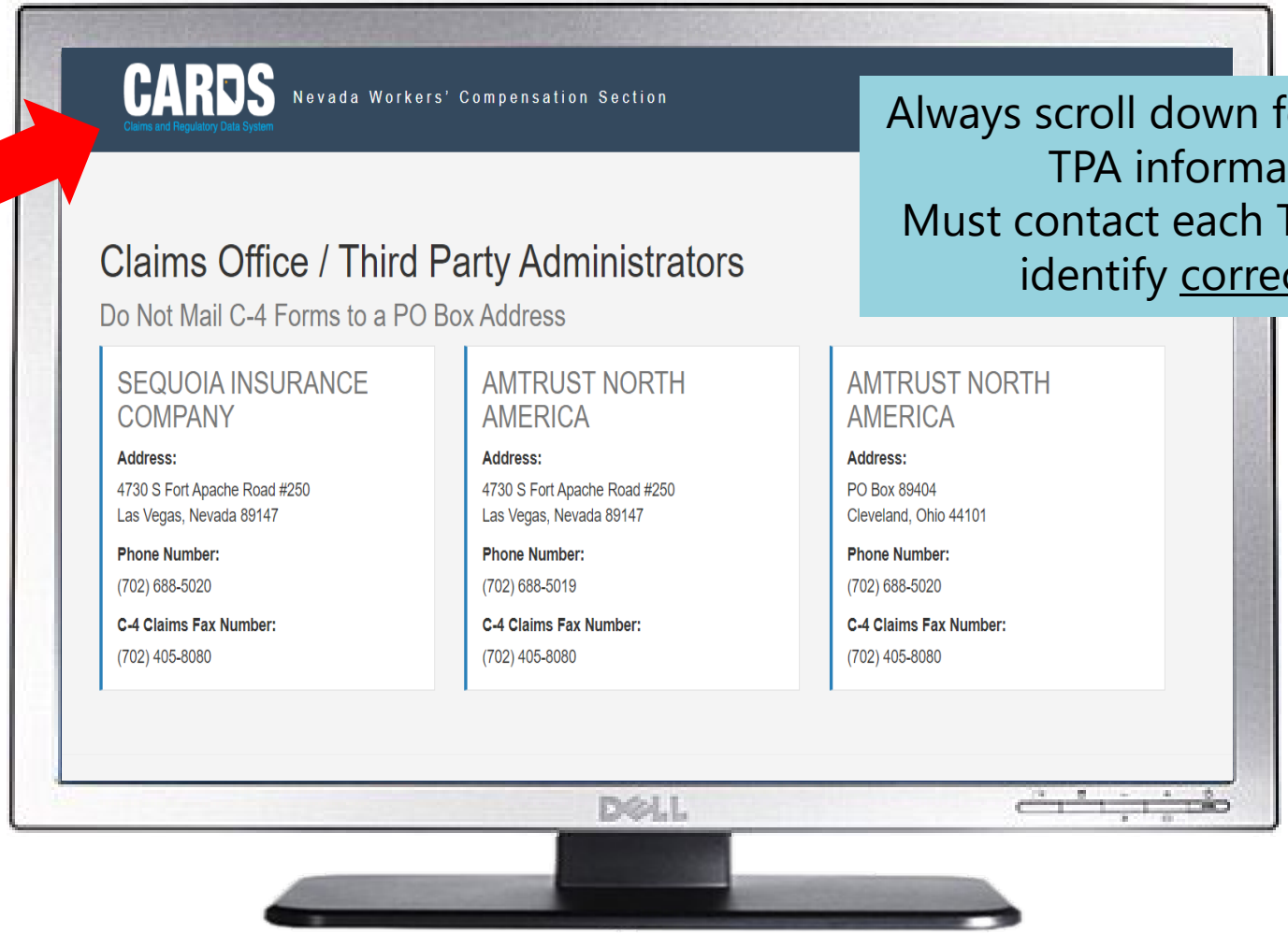
Policy Information



Policy/TPA Information



TPA Information/CARDS



Always scroll down for additional TPA information.
Must contact each TPA listed to identify <u>correct</u> 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.

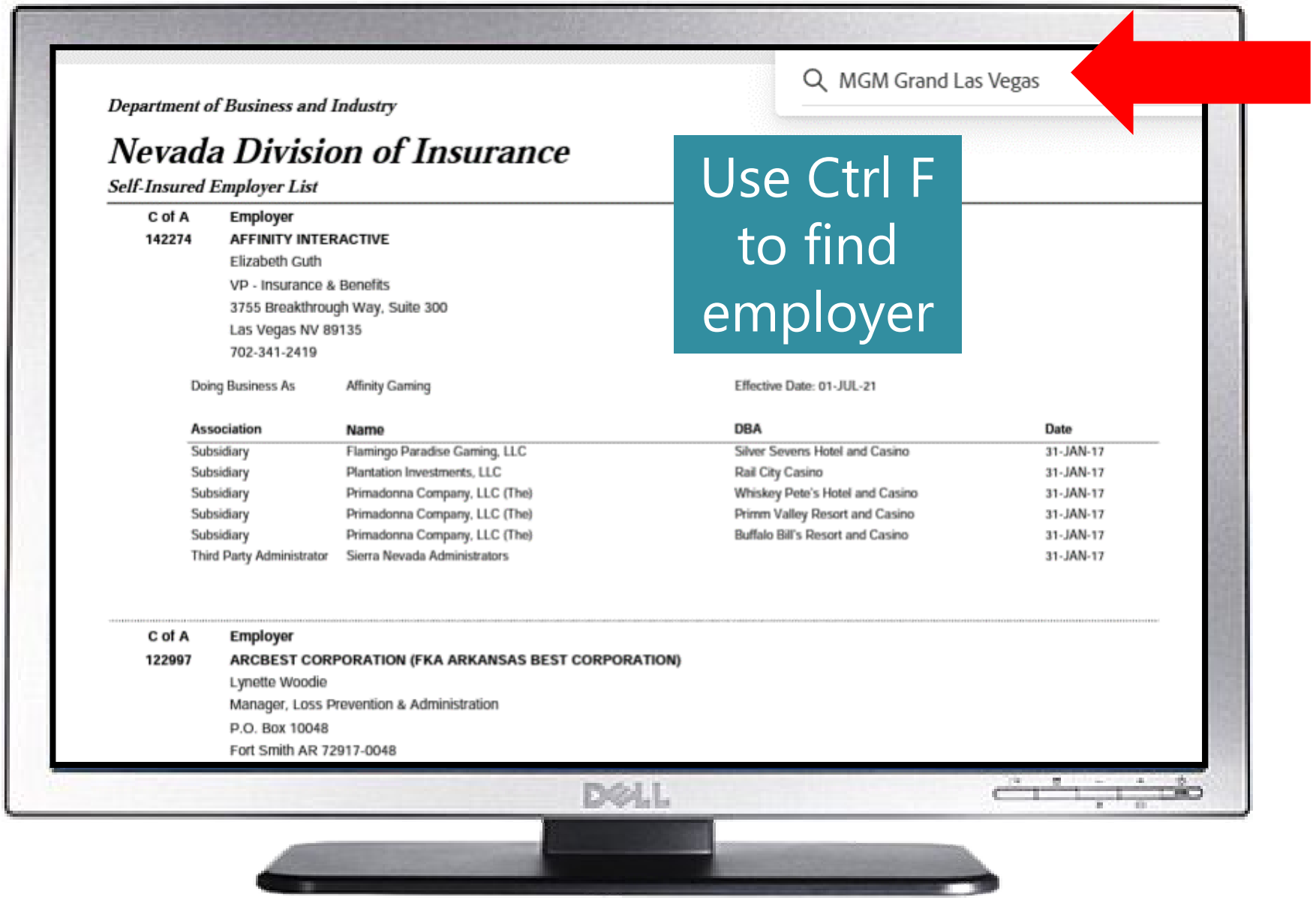
Step 3 Go to the Division of Insurance (DOI) website at http://doi.nv.gov/. Hover on the "Quick Links" tab to click "Self-Insured Workers' Compensation". Select either "Self-Insured Employer List" or "Association List."

Self-Insured Employer Lookup: Nevada Division of Insurance

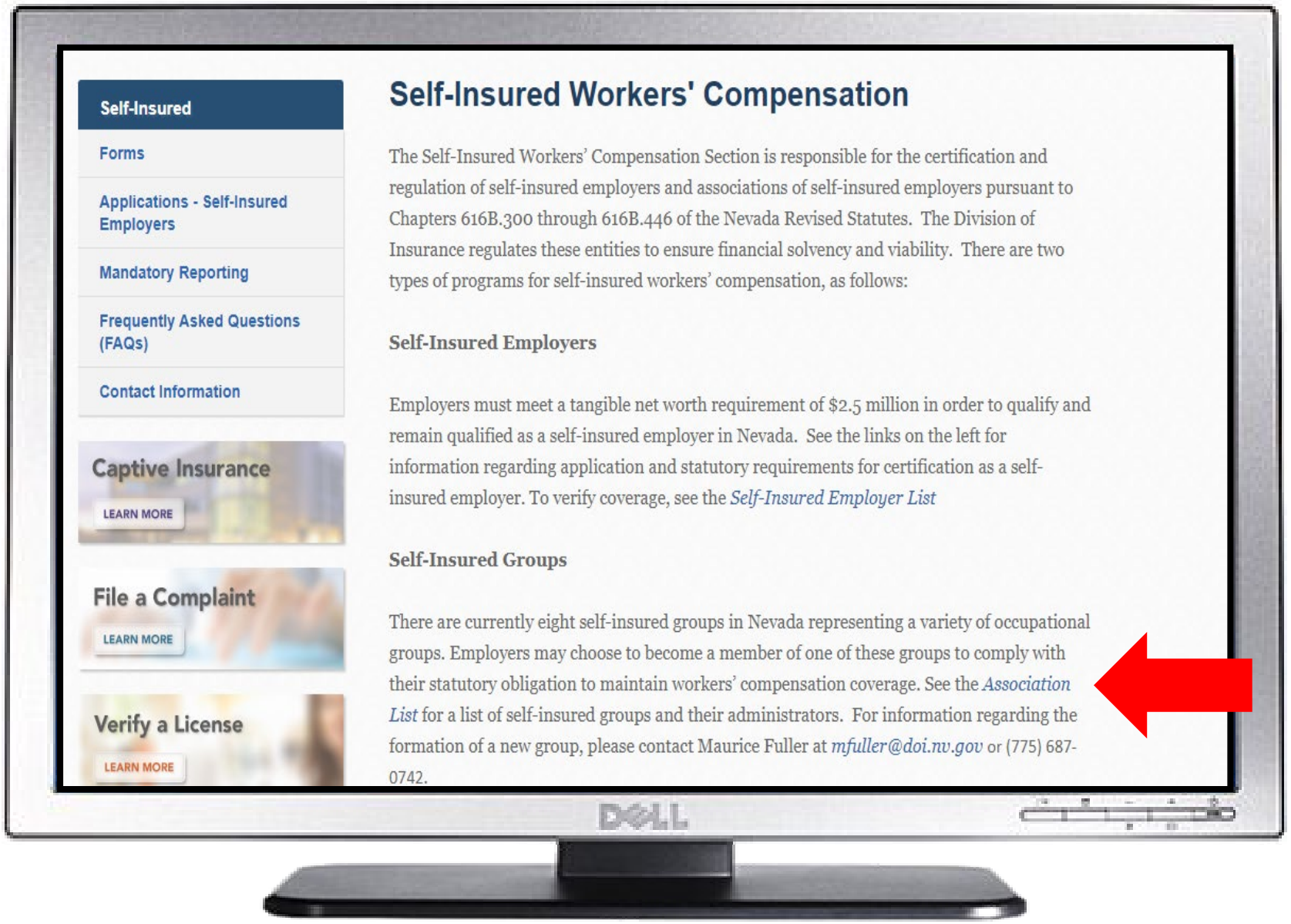
http://doi.nv.gov/

Self-Insured Employer Lookup: Nevada Division of Insurance

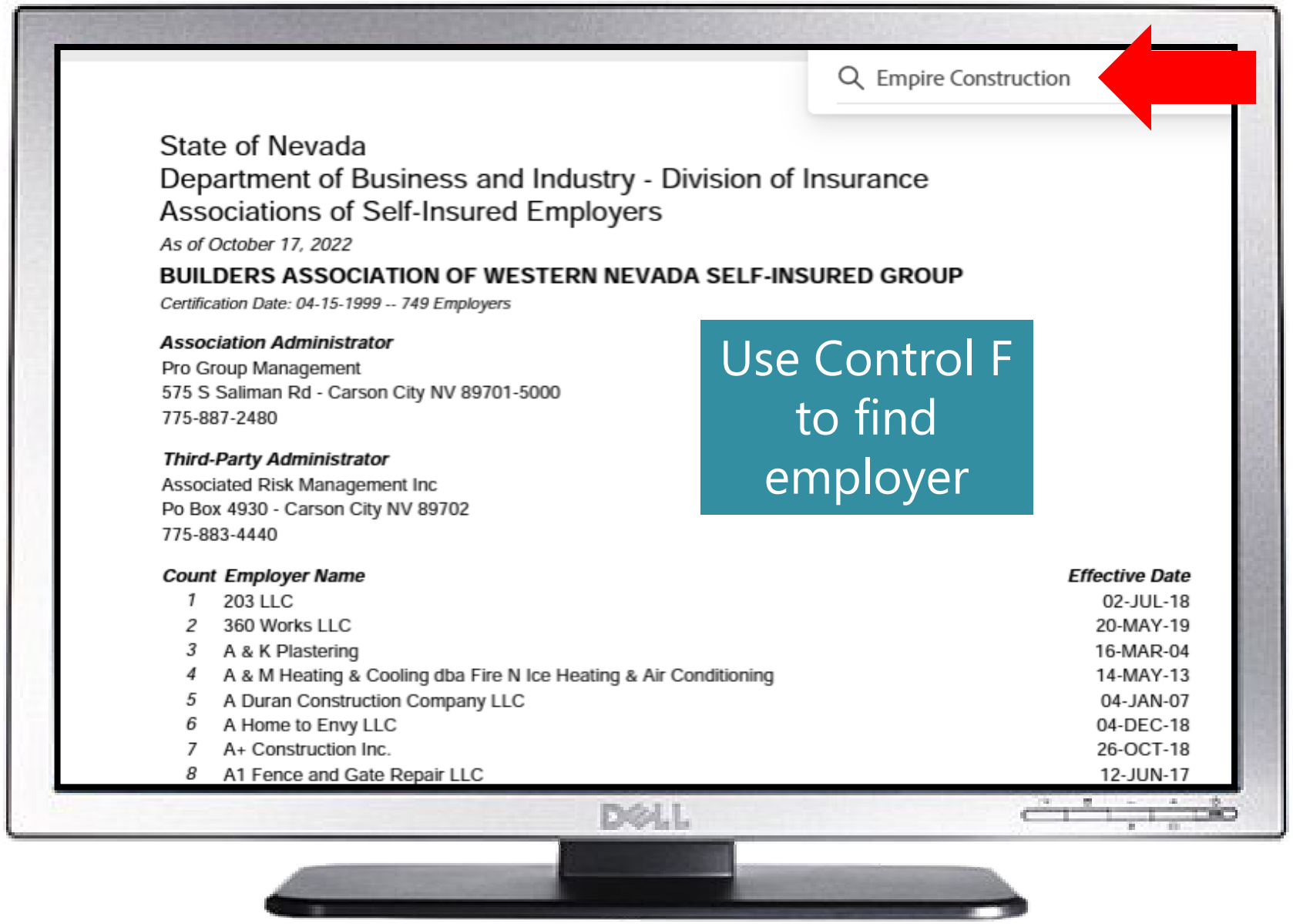
Self-Insured Employer Lookup: Nevada Division of Insurance



Self-Insured Association Member Lookup: Nevada Division of Insurance

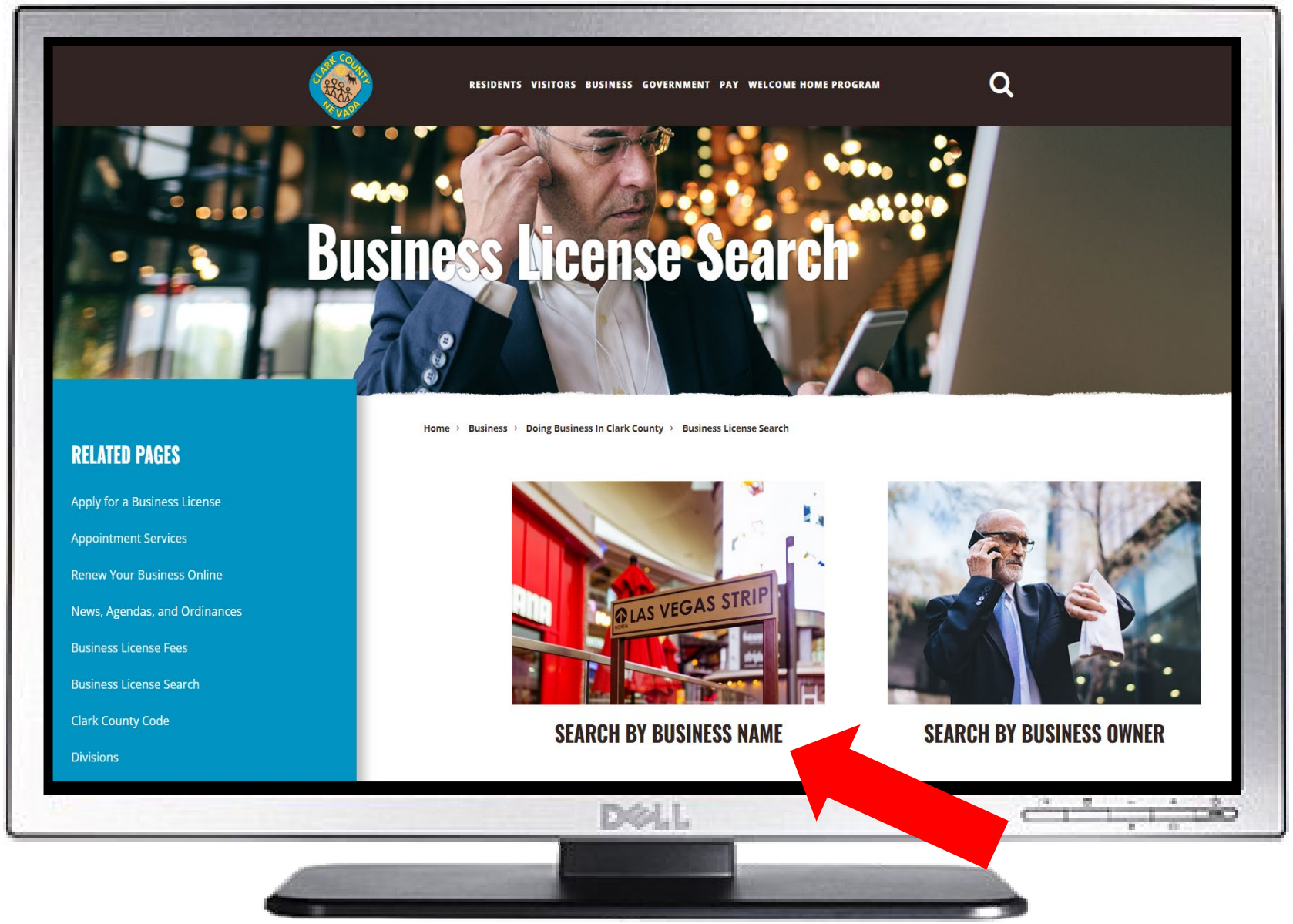


Self-Insured Association Member Lookup: Nevada Division of Insurance

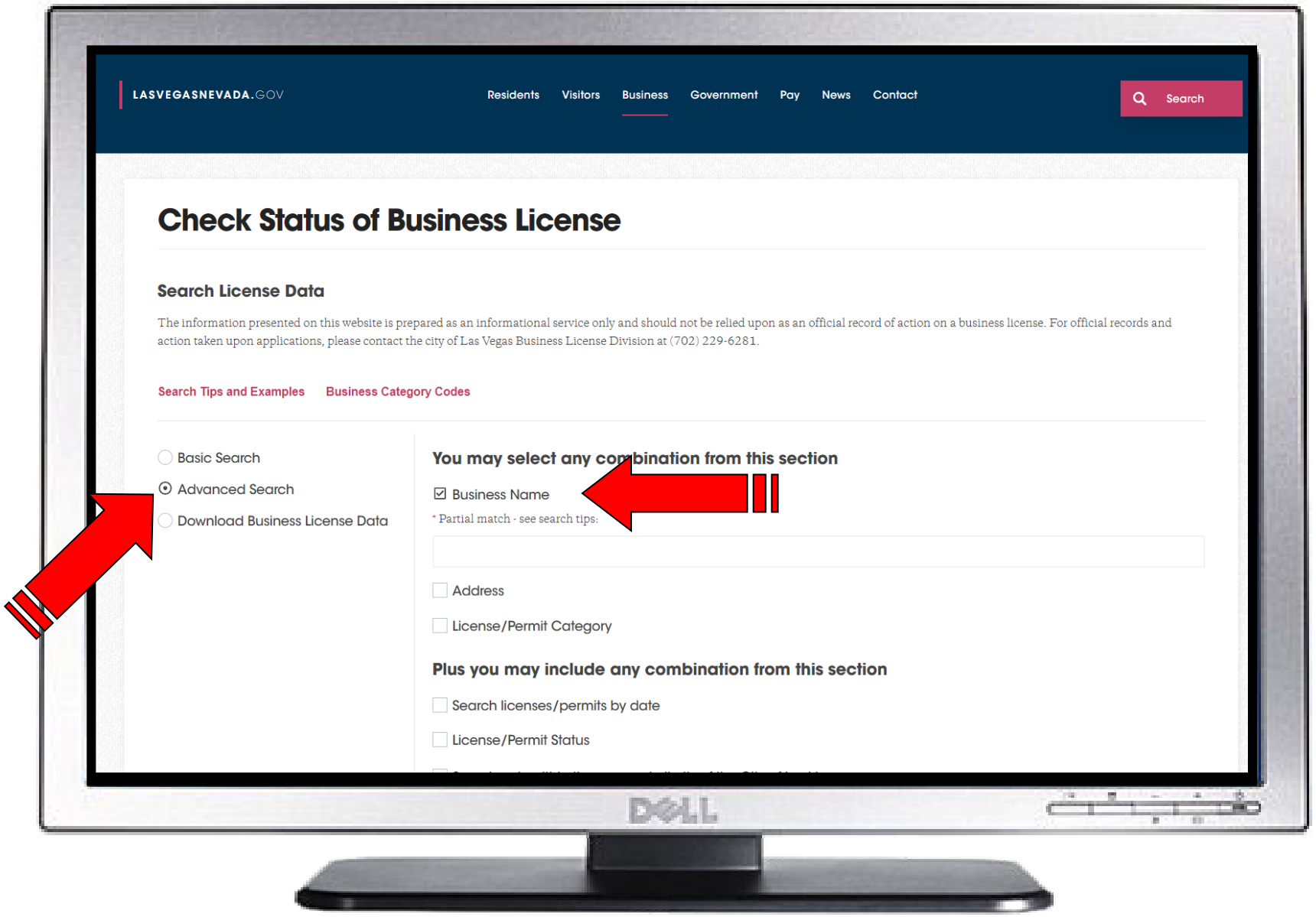


But what if I can’t find it in CVS?

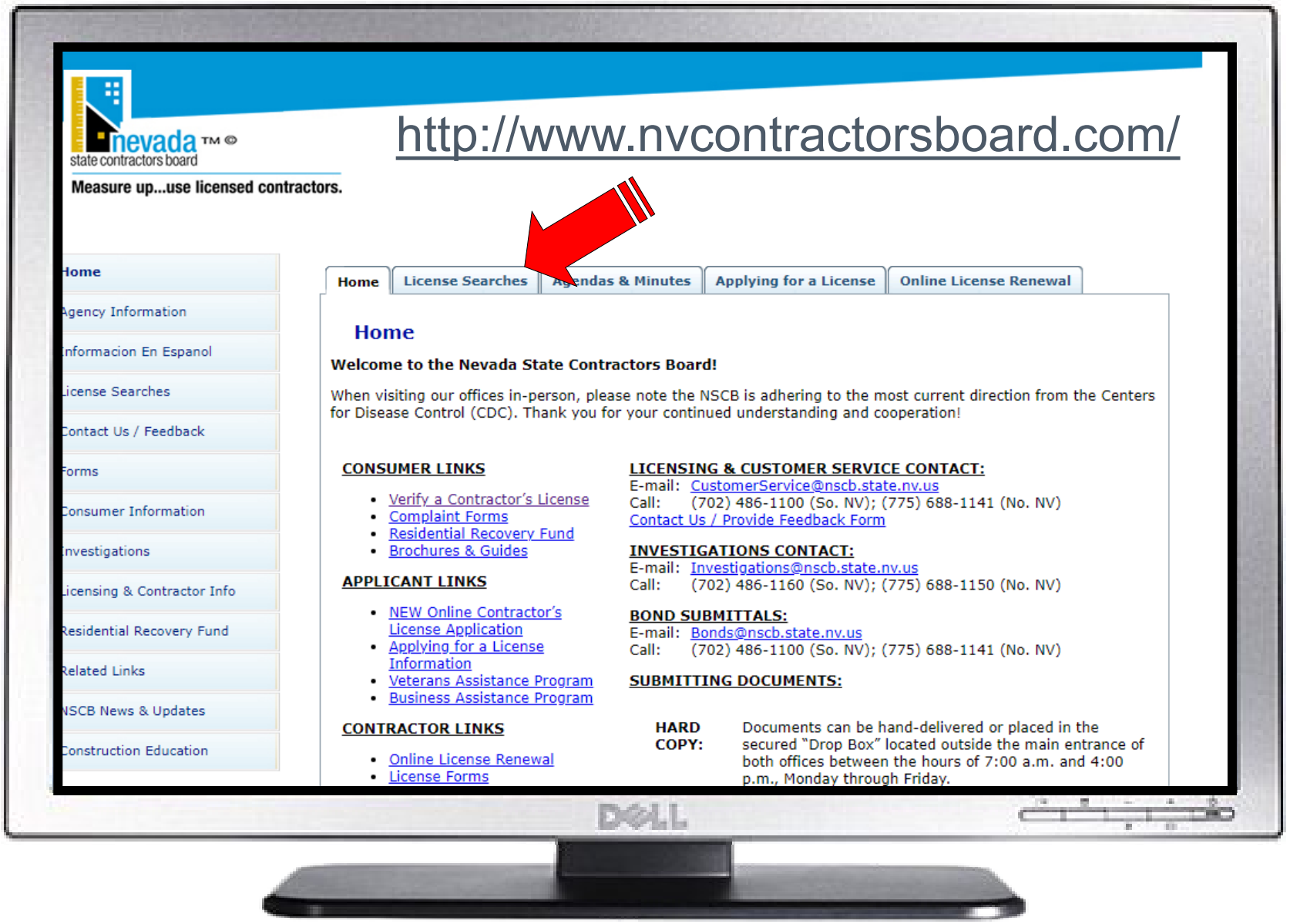
Business Name Lookup: Clark County Business License Search



Business Name Lookup: Clark County Business License Search

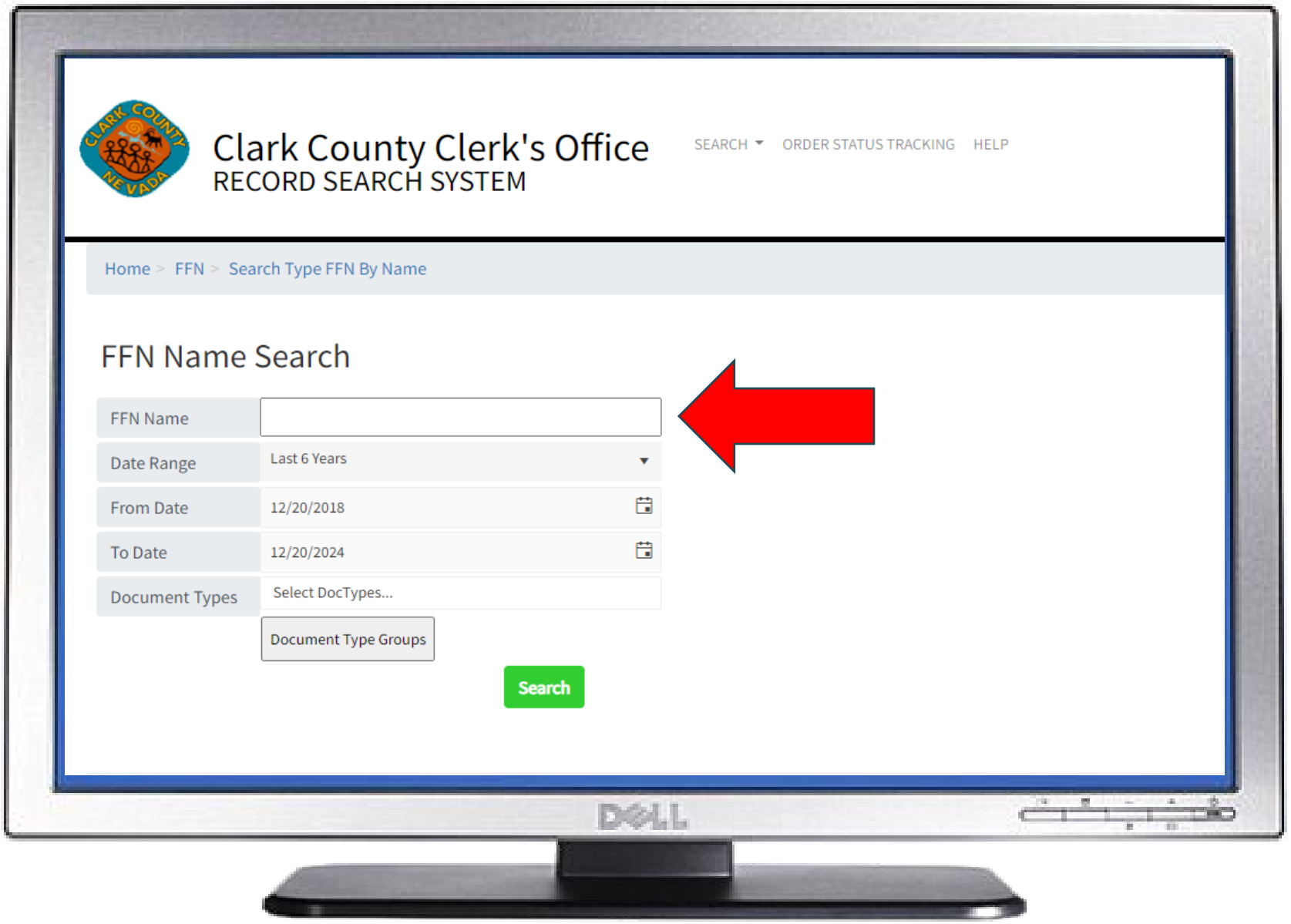


Business Name Lookup: Nevada Contractors Board



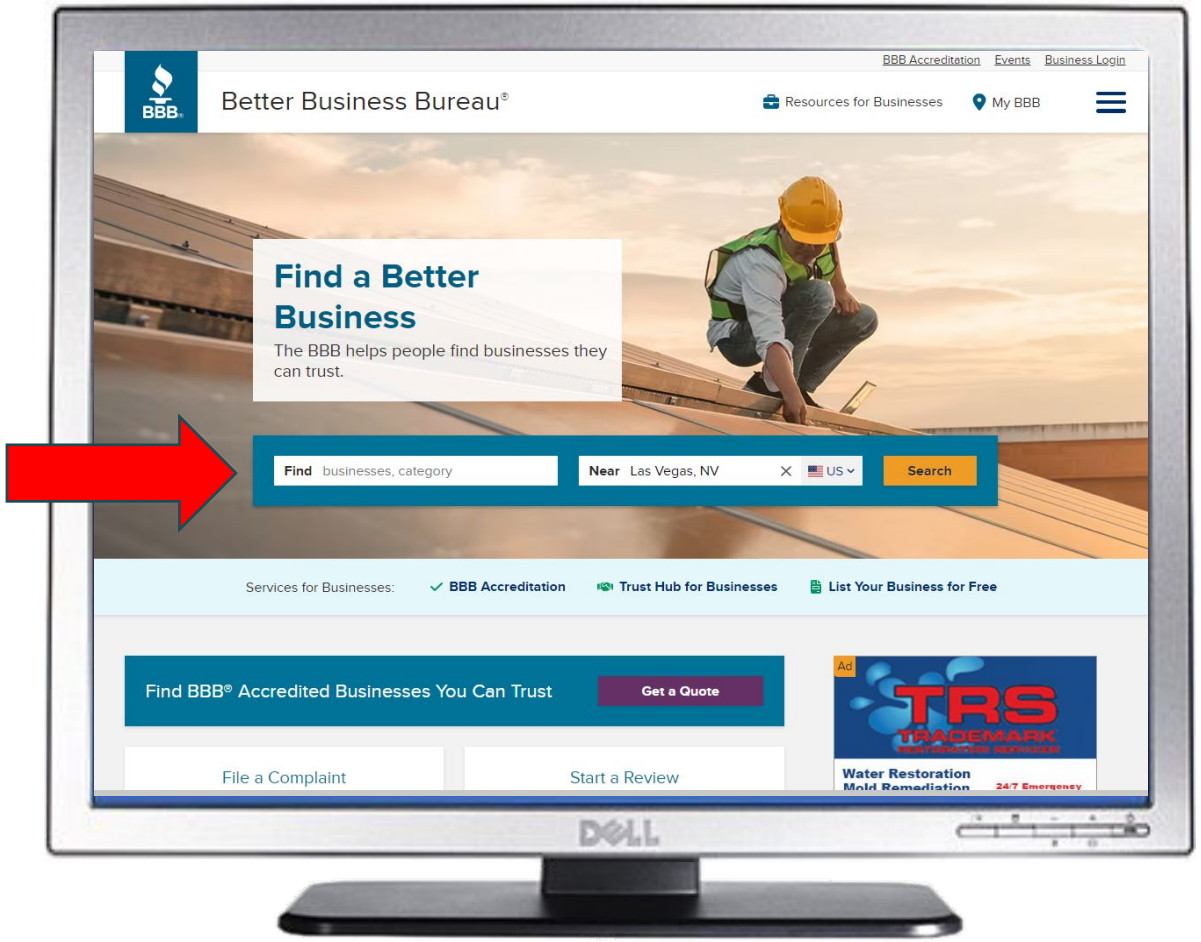
Business Entity Search: SilverFlume

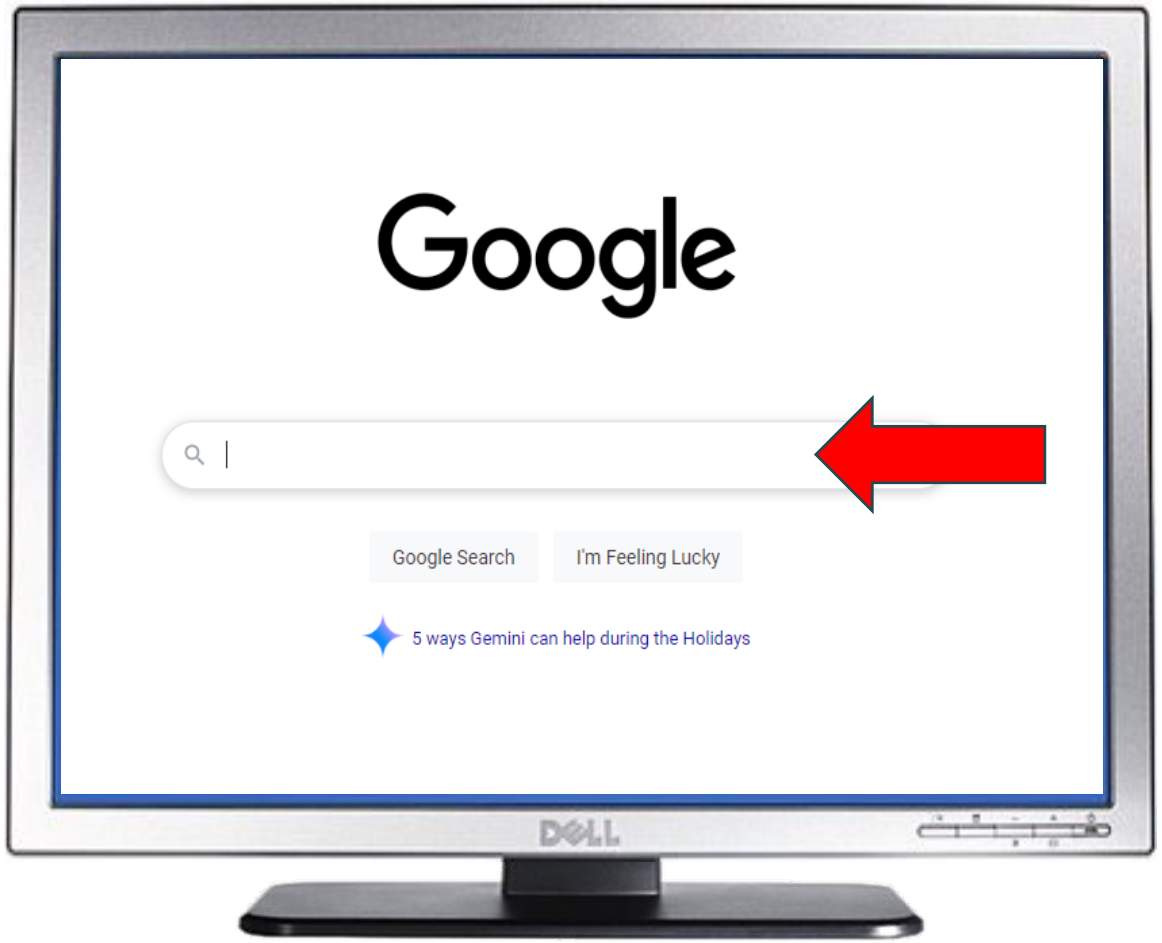
DBA Search: Clark County Fictitious Names



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

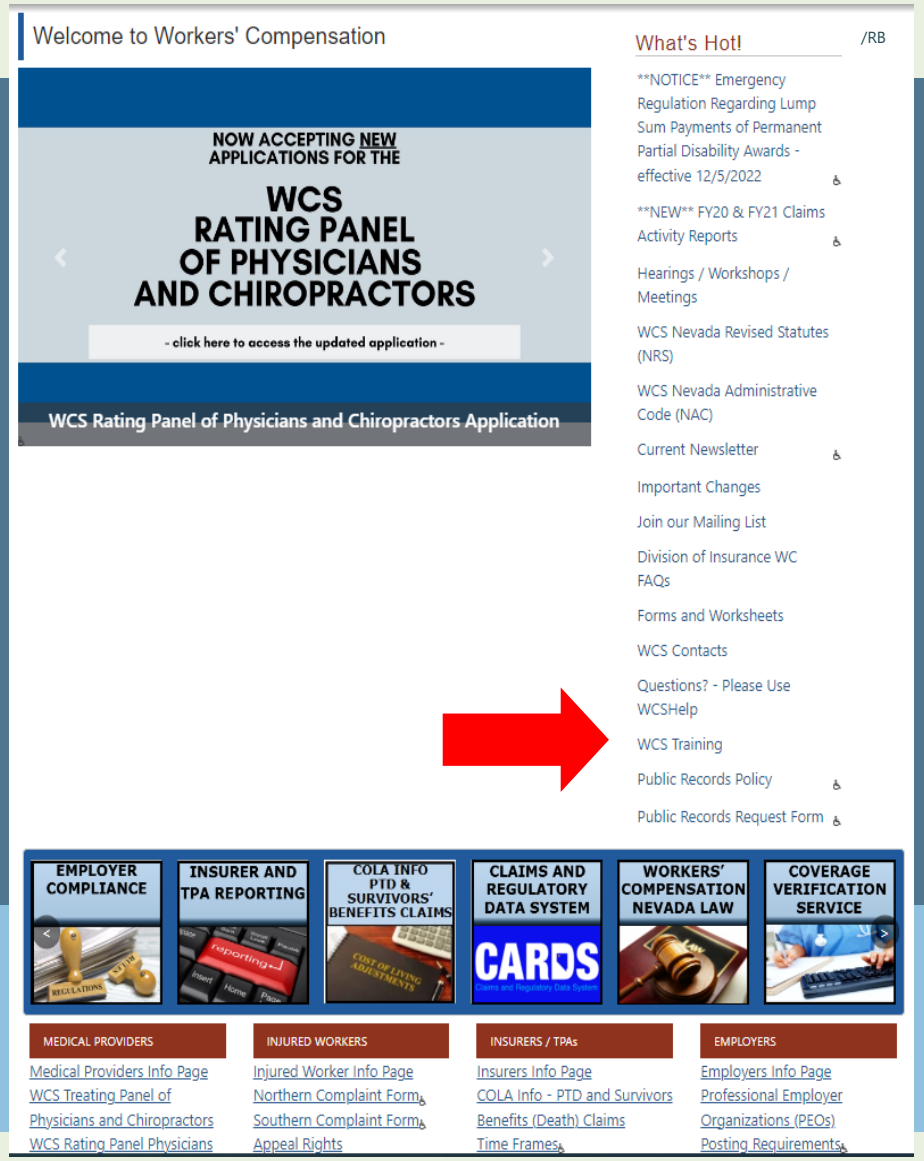
http://www.dol.gov/owcp/

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.



WCS WEBSITE

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

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

/RB

/rb

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