State of Nevada
Department of Business and Industry
Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – **PART 1**
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – **PARTS 1 & 2**

Submitted By:	☐ Insurer ☐ TPA
Company:	
Submitter Name:	
Telephone:	
Email:	

PART 1 (Claim Information)

Insurer Name:	
Insurer FEIN:	
Insurer Certificate Number:	
Claimant's Employer:	
Claimant's Name:	First: Last:
Claim Number:	
Claim Disposition:	☐ Accepted ☐ Denied
Reason for Denial:	☐ 1-Pending medical investigation ☐ 2-Negative test/no exposure ☐ 3-Not in course/scope ☐ 4-Not compensable/no disease ☐ 5-Late reporting ☐ 6-Failure to correct predisposing condition ☐ 7-Misc (duplicate claim, wrong insurer/uninsured, etc)

CLAIMANT (Choose one) & CLAIM ACCEPTED/DENIED PURSUANT TO NRS (Choose one):

☐ **FIREFIGHTER**
- ☐ NRS 617.453 CANCER
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

☐ **ARSON INVESTIGATOR**
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES

☐ **POLICE OFFICER** (PEACE OFFICERS PER NRS 289.010 INCLUDED)
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS
- ☐ NRS 617.487 HEPATITIS

☐ **EMERGENCY MEDICAL ATTENDANT**
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

Date of Injury:		
Date Claim (C4) Received by Insurer/TPA:		
Date Accepted/Denied:		
Estimated Medical Costs of Claim:	$	Diagnosis Confirmed: ☐ Yes ☐ No
Description of Claim:		
Initial Claim Closure Date:	Date Claim Reopened (if applicable):	Subsequent Claim Closure Date (if applicable):

PART 2 (Appeal Information)

INITIAL APPEAL OF: ☐ **CLAIM DENIAL** ☐ **CLAIM ACCEPTANCE**	**SUBSEQUENT APPEAL OF DECISION BY:** ☐ **HO** ☐ **AO** ☐ **DC**
Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer	Appealed By: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer
Appeal Number:	Appeal Number:
Date Appeal Filed:	Date Appeal Filed:
Hearing Date:	Hearing Date:
Decision Date:	Decision Date:
Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain):	Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain):
Decision By: ☐ Hearing Officer ☐ Appeals Officer	Decision By: ☐ Appeals Officer ☐ District Court ☐ Supreme Court

Fax completed form to (702) 486-8712 or email to WCSHelp@dir.nv.gov | Attention: R&A Unit