State of Nevada
Division of Industrial Relations
Workers' Compensation Section

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

☐ **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

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

☐ **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

Email completed forms to wcsra@dir.nv.gov