State of Nevada

Workers' Compensation Section

C-4 Forms: Health Care Provider (HCP) Responsibilities and Coverage Verification

Every C-4 = Person Who Matters

C-4 Form

Employee's Claim for Compensation / Report of 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 ☐M ☐F	Claim Number (Insurer's Use Only)
Home Address			Age / Height	Weight	Social Security Number
City	State	Zip		Telephone	
Mailing Address	City	State	Zip		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 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 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 Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
Address		INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone
Doctor's Signature		Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

C-4 to Correct Insurer/Third-Party Administrator (TPA)

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

Transit Time
2-3 Days

Insurer/TPA Approve or deny claim
30 DAYS

C-4 to Incorrect Insurer/TPA

C-4 Submission by Provider

2-3 Days

Incorrect Insurer/ TPA

Days/Weeks Months

DIR/WCS

Correct Insurer/TPA

NRS 616C.065 Claim Acceptance or Denial 30 Days

HCP Reimbursement by Correct Insurer/TPA

(Per Med Fee)
Billing Submission
By Medical Provider
90 Days

Transit Time
2-3 Days

Insurer/TPA
Pay or deny medical bill
45 Days

C-4 Form - Employee's 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 ☐ M ☐ F	Claim Number (Insurer's Use Only)
Home Address	Age	Height	Weight	Social Security Number
City / State / Zip			Telephone	
Mailing Address / City / State / Zip				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 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 Signature

C-4 Form - Employee's Section

General Section

- Full name
- **Correct** address and telephone number

Employer Section

- **Correct** corporate name
- **Correct** "Doing Business As" (DBAs)
- **Correct** address and telephone number

Accident or Disease

- Date and time
- Address or location of accident

Emergency Situations

- Employer/HCP may complete C-4 Form
- Make notation regarding circumstances and note the person who completed C-4 Form
- HCP **must** obtain injured employee's original signature as soon as possible

D-2 Form

Brief Description of Rights and Benefits

Must be provided to injured employee at 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.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor 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 chiropractor 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 chiropractor from the Panel of Physicians and Chiropractors. 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 chiropractor 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 and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor 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 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 Appeal 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, 400 West King Street, Suite 400, Carson City, Nevada 89703, 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, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

D-2 (rev. 01/20)

C-4 Form
Medical Provider's Section

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:

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

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 Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
Address		INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone
Doctor's Signature		Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE

Form C-4 (rev.10/07)

C-4 Form Submission HCPs' Responsibilities

- Within 3 working days, complete and file Form C-4 with employer and **CORRECT** insurer/TPA
- Use form prescribed by Division of Industrial Relations (DIR)
  - C-4s are available on the WCS website dir.nv.gov/WCS/forms_and_worksheets
- Maintain sufficient supply of appropriate forms
- Fines for untimely or incomplete form submission

WCS
Coverage Verification Service
(CVS)

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

System Users

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

CVS Limitations

- Includes only employers with private insurance carriers
- Does NOT include employers that are self-insured, part of an association or uninsured
- Enter **date of injury**, not date of search
- Accuracy of available information dependent on accuracy of information provided by carriers

** Searches resulting in NO MATCHES on CVS do not necessarily indicate coverage does not exist; search Other Helpful Links on CVS webpage

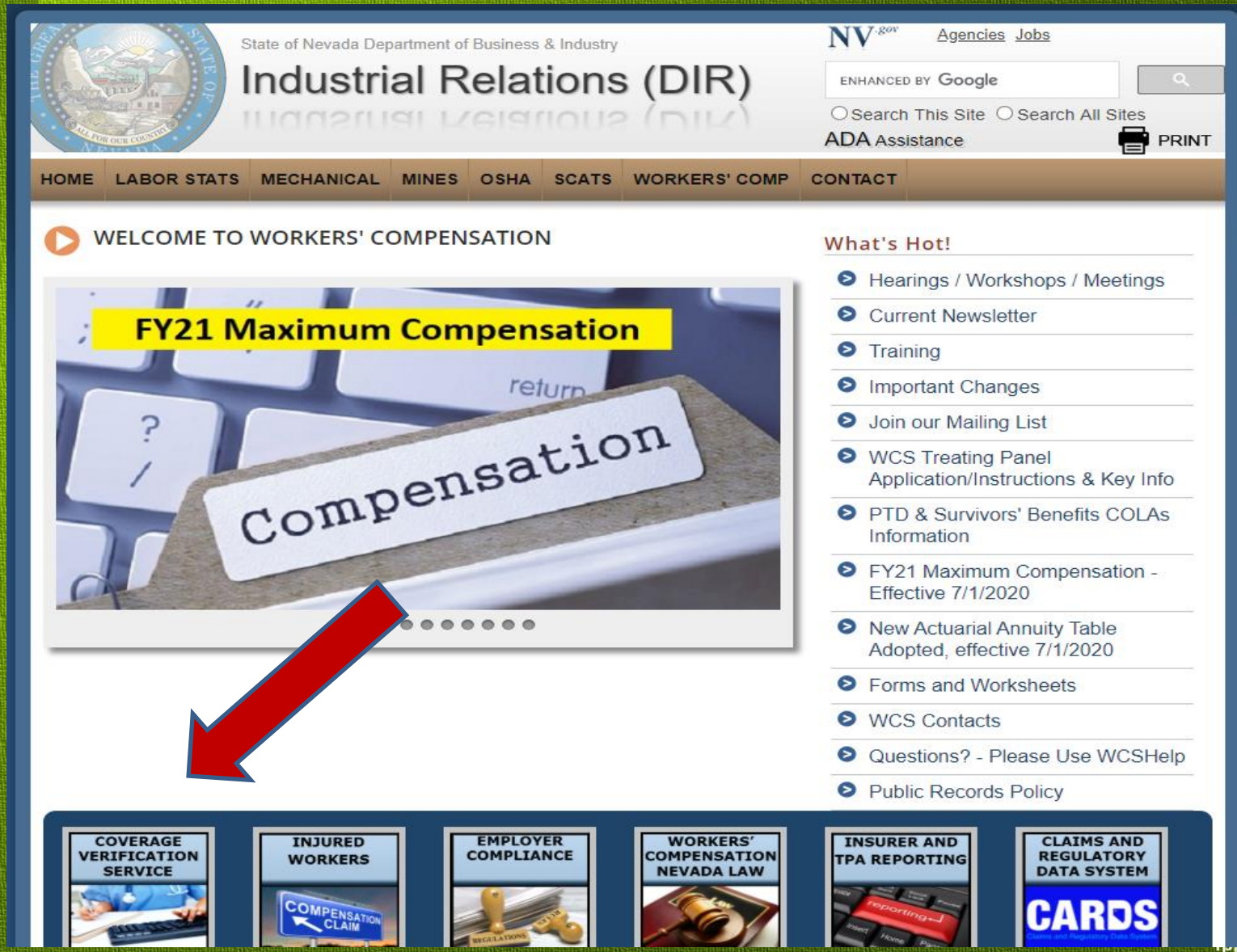
Steps For Obtaining Insurance Information

Step 1 Ask injured employee, if possible. **Verify employer name, address and phone number.**

Step 2 Use the Coverage Verification Service (CVS) on the WCS website: **http://dir.nv.gov/WCS/home/**

Coverage Verification Service

dir.nv.gov/WCS/home/



CVS Notice & Disclaimer Page

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 wrote a 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.

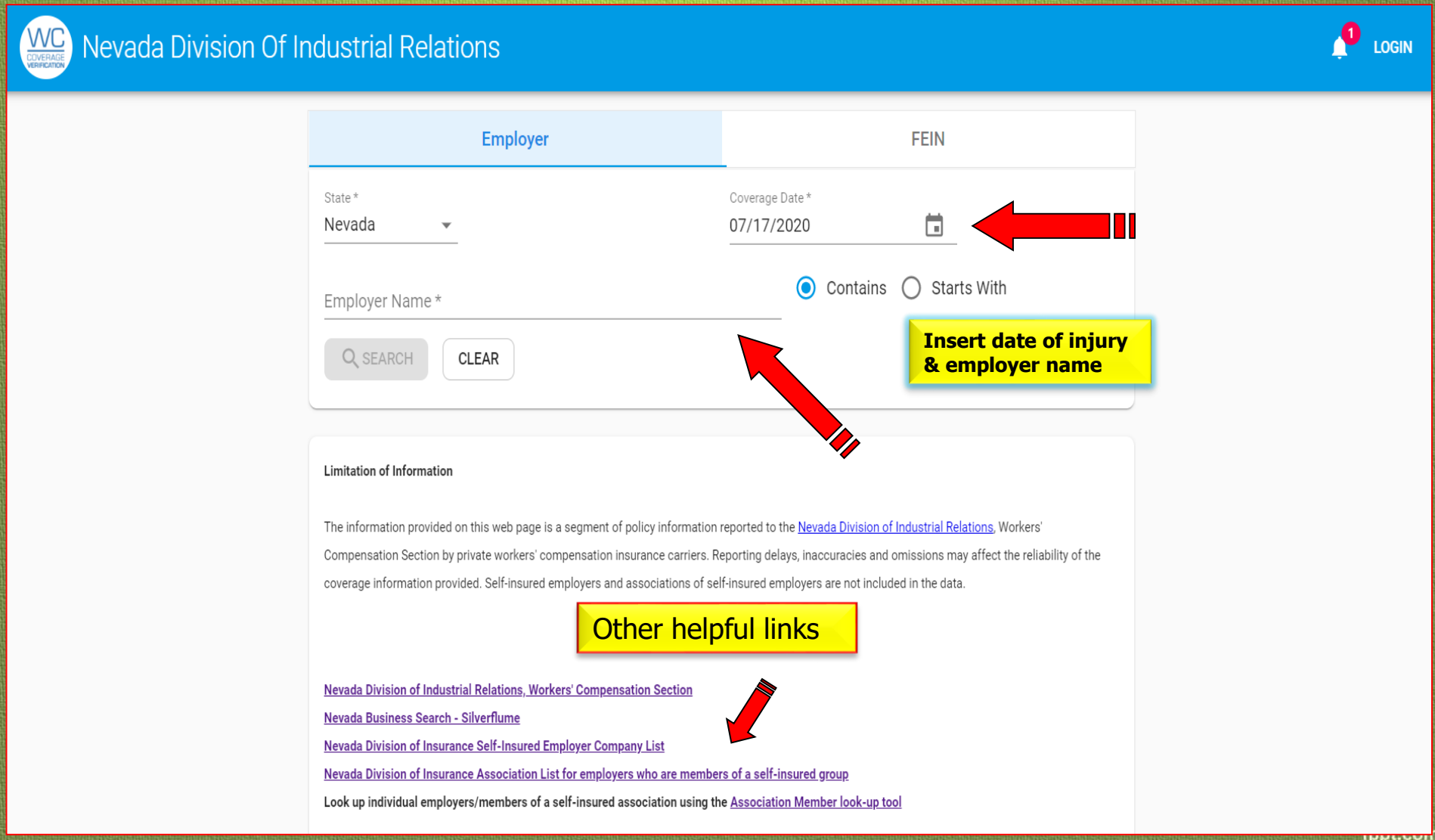
Limitation of Available Information:
If an employer query does not produce any result(s) this may not mean that the employer does not have insurance or is operating in violation of state law. Coverage information may not be available or complete for all employers due to limitations with the policy information. 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, such as reCAPTCHA. Any attempt to do so is prohibited and will result in you being unable to access 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.

This site is protected by reCAPTCHA and the Google Privacy Policy and Terms of Service apply.

PRIVACY POLICY

✓ ACCEPT

Date of Injury Employer Information



Policy Information

Employer | FEIN

State * Nevada

Coverage Date * 07/17/2020

Employer Name * West Sahara

Contains | Starts With

SEARCH | CLEAR

Results do not imply coverage for the employer in this state. Make a selection to verify coverage.

Filter by name

4545 WEST SAHARA AVE LLC
Policy Number: 53WECAA2H2Y

SAHARA WEST URGENT CARE & WELLNESS LLC
Policy Number: UB8L5812741942G

AUTONATION BUICK GMC WEST SAHARA
Policy Number: C66924427

WEST SAHARA LLC
Policy Number: QWC1096690

Click on correct employer

FLETCHER JONES LAS VEGAS INC. FLETCHER JONES WEST SAHARA LTD LLC DBA FLETCHER JONES
Policy Number: 90210010500191

IDC WEST SAHARA INC
Policy Number: EIG204174206

Policy/TPA Information

WEST SAHARA LLC

TRACK POLICY

Insurance Coverage Provider
SEQUOIA INSURANCE CO

Policy Number
QWC1096690

Coverage Date
07/17/2020

CLICK HERE FOR CLAIM PROCESSING INFORMATION.

Click for TPA Info

10 Employer Location(s)

Filter by name or address

WEST SAHARA LLC
8175 W SAHARA AVE
LAS VEGAS, NV 89117-1936

DEE LEE INC
3081 N RAINBOW BLVD
LAS VEGAS, NV 89108-4577

DEE LEE INC
600 E SAHARA AVE STE 1
LAS VEGAS, NV 89104-2967

DEE LEE INC
6175 SPRING MOUNTAIN RD STE 200
LAS VEGAS, NV 89146-8845

MARIE CALLENDERS DBA
3081 N RAINBOW BLVD
LAS VEGAS, NV 89108-4577

MARIE CALLENDERS DBA
600 E SAHARA AVE STE 1
LAS VEGAS, NV 89104-2967

MARIE CALLENDERS DBA
6175 SPRING MOUNTAIN RD STE 200
LAS VEGAS, NV 89146-8845

MARIE CALLENDER'S DBA
600 E SAHARA AVE
LAS VEGAS, NV 89104-2967

MARIE CALLENDER'S DBA
8175 W SAHARA AVE
LAS VEGAS, NV 89117-1936

MC CATERING LLC

TPA Information

CARDS
Claims and Regulatory Data System
Nevada Workers' Compensation Section

Claims Office / Third Party Administrators

Do Not Mail C-4 Forms to a PO Box Address

SEQUOIA INSURANCE COMPANY

Address:
4730 S Fort Apache Road #250
Las Vegas, Nevada 89147

Phone Number:
(702) 688-5020

C-4 Claims Fax Number:
(702) 405-8080

AMTRUST NORTH AMERICA

Address:
4730 S Fort Apache Road #250
Las Vegas, Nevada 89147

Phone Number:
(702) 688-5019

C-4 Claims Fax Number:
(702) 405-8080

AMTRUST NORTH AMERICA

Address:
PO Box 89404
Cleveland, Ohio 44101

Phone Number:
(702) 688-5020

C-4 Claims Fax Number:
(702) 405-8080

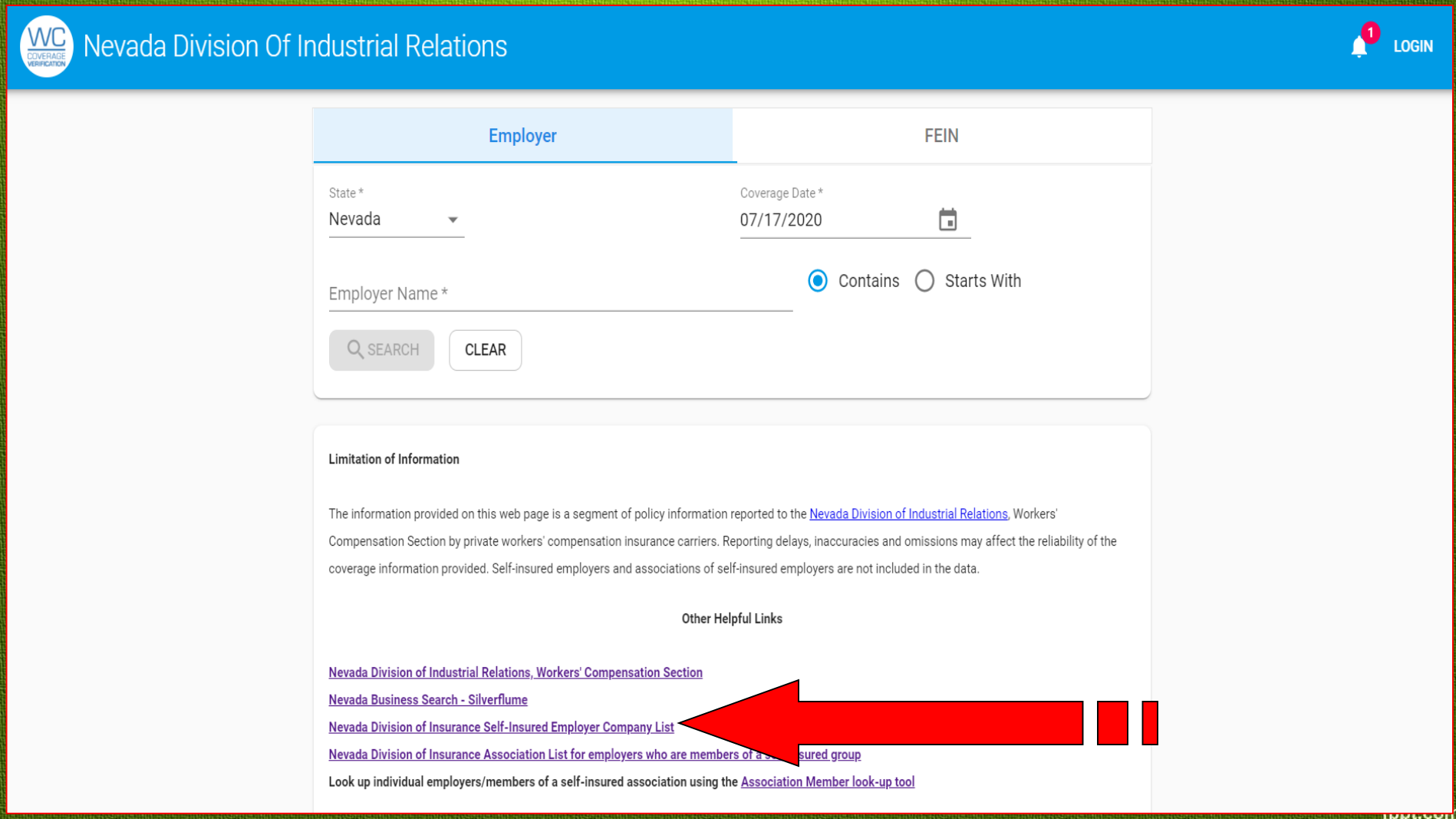
***Always scroll down for additional TPA information.**
***Must contact each TPA listed to identify correct TPA**

Steps For Obtaining Insurance Information (Continued)

***Only needed if unable to locate insurer/TPA on CVS. Otherwise, skip to Step 4.**

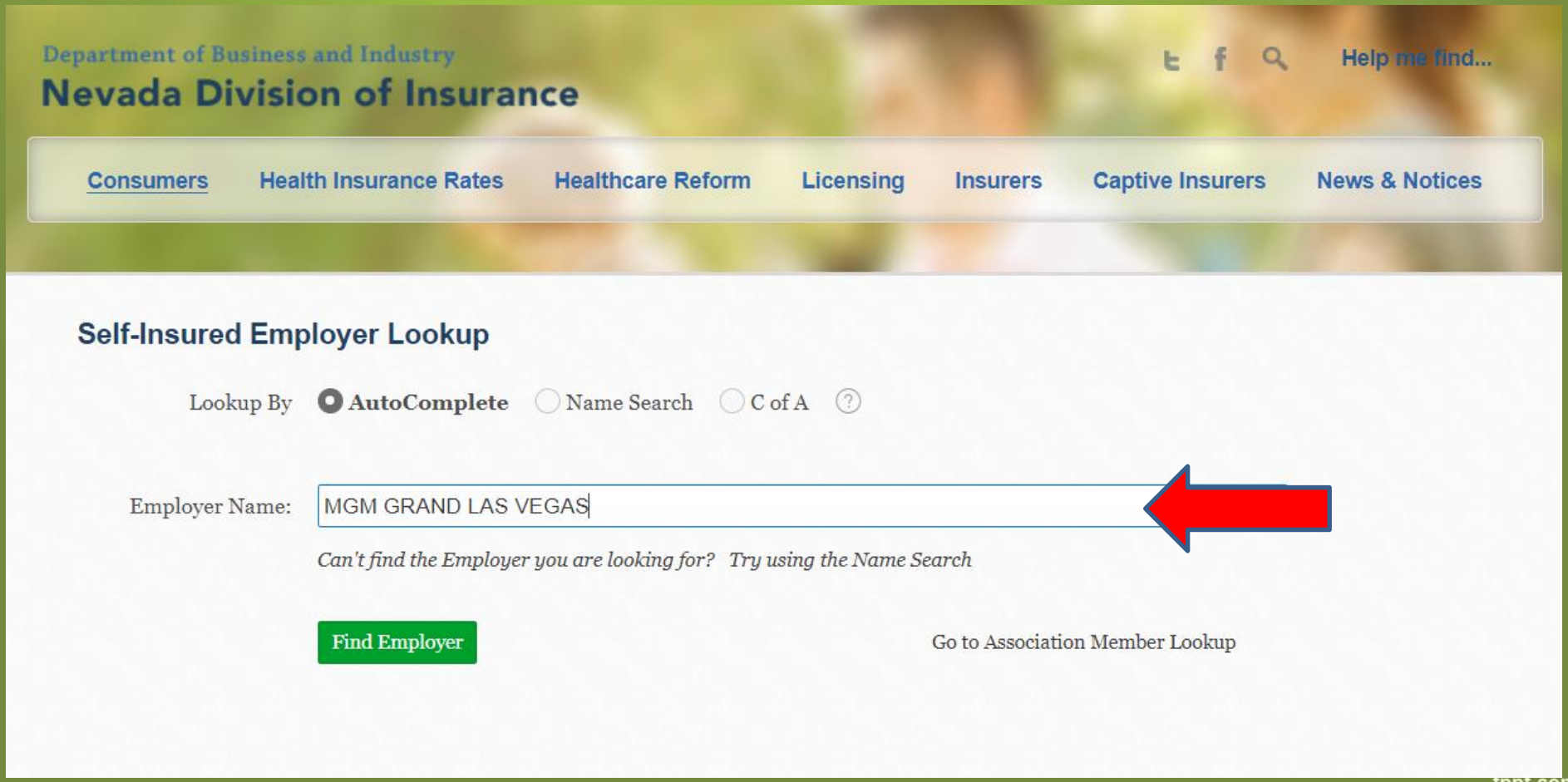
Step 3 Go to the Division of Insurance (DOI) website at http://doi.nv.gov/. Select "Quick link…" on the top right to locate and click on "Self-insured Workers' Compensation."

Division Of Insurance - Self Insured List



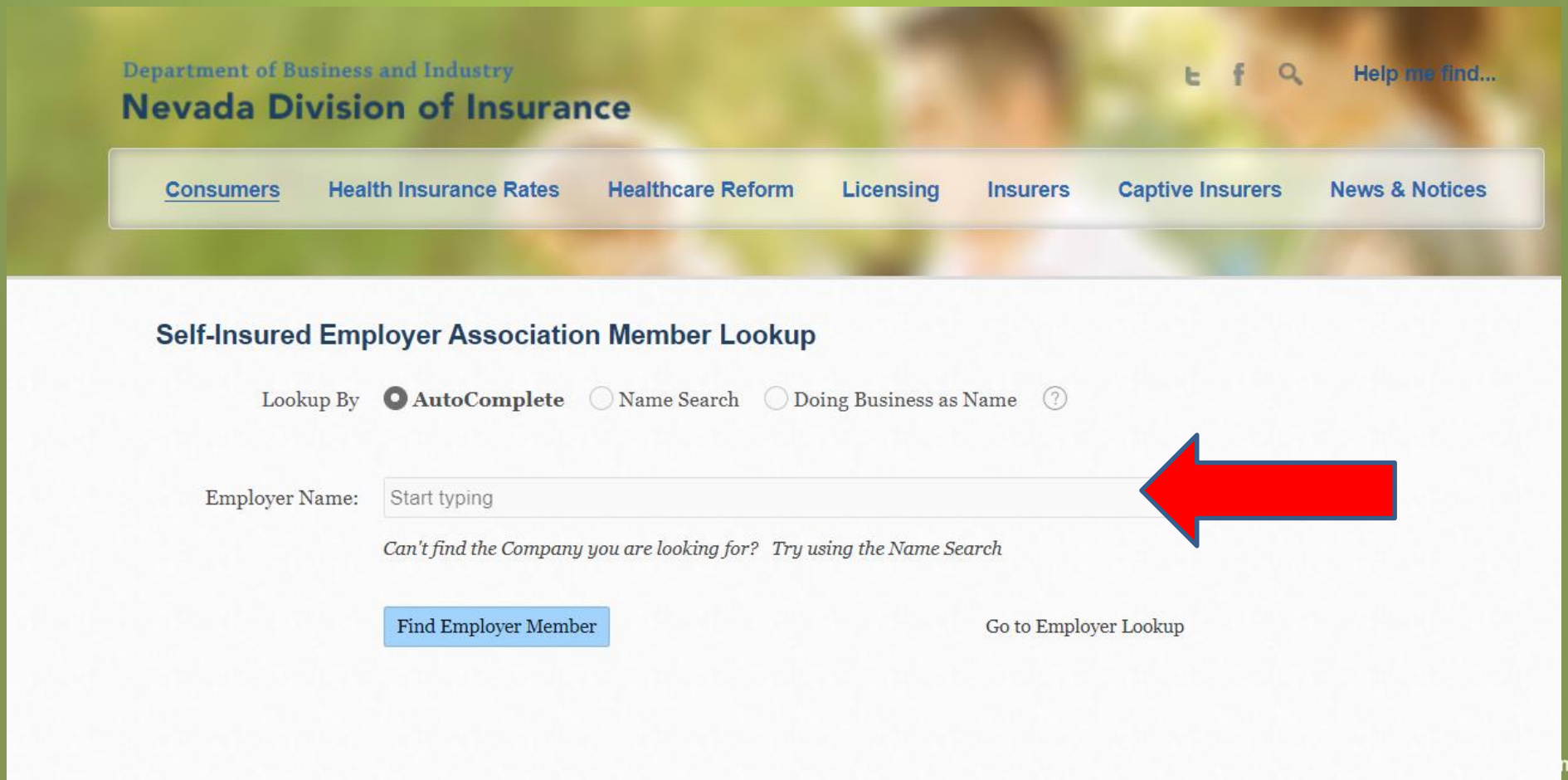
Self-Insured Employer Lookup

http://di.nv.gov/ins/f?p=112:17

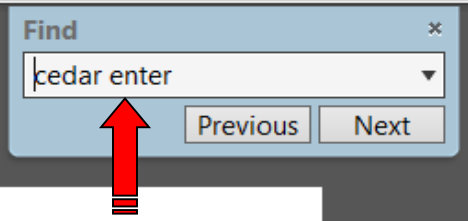


Self-Insured Association Member Lookup

http://di.nv.gov/ins/f?p=112:15



Self-insured Contact Information



Department of Business and Industry

Nevada Division of Insurance

Self-Insured Employer List

Association	Name	Date
Third Party Administrator	NEVADA ALTERNATIVE SOLUTIONS INC	11-SEP-

C of A 199

Employer
CEDAR ENTERPRISES
Kia Summers
Human Resources Representative
1328 Dublin RoadSuite 300
Columbus OH 43215
614-737-7808

TPA Information

Association	Name	Date
Third Party Administrator	SIERRA NEVADA ADMINISTRATORS INC	11-SEP-13
Subsidiary	WENDY'S OF LAS VEGAS, INC.	01-JAN-94

C of A 130131

Employer
CHURCHILL COUNTY SCHOOL DISTRICT
Phyllys Dowd
Director of Business Services
690 S MAINE ST
FALLON NV 89406-3807
775-428-7220

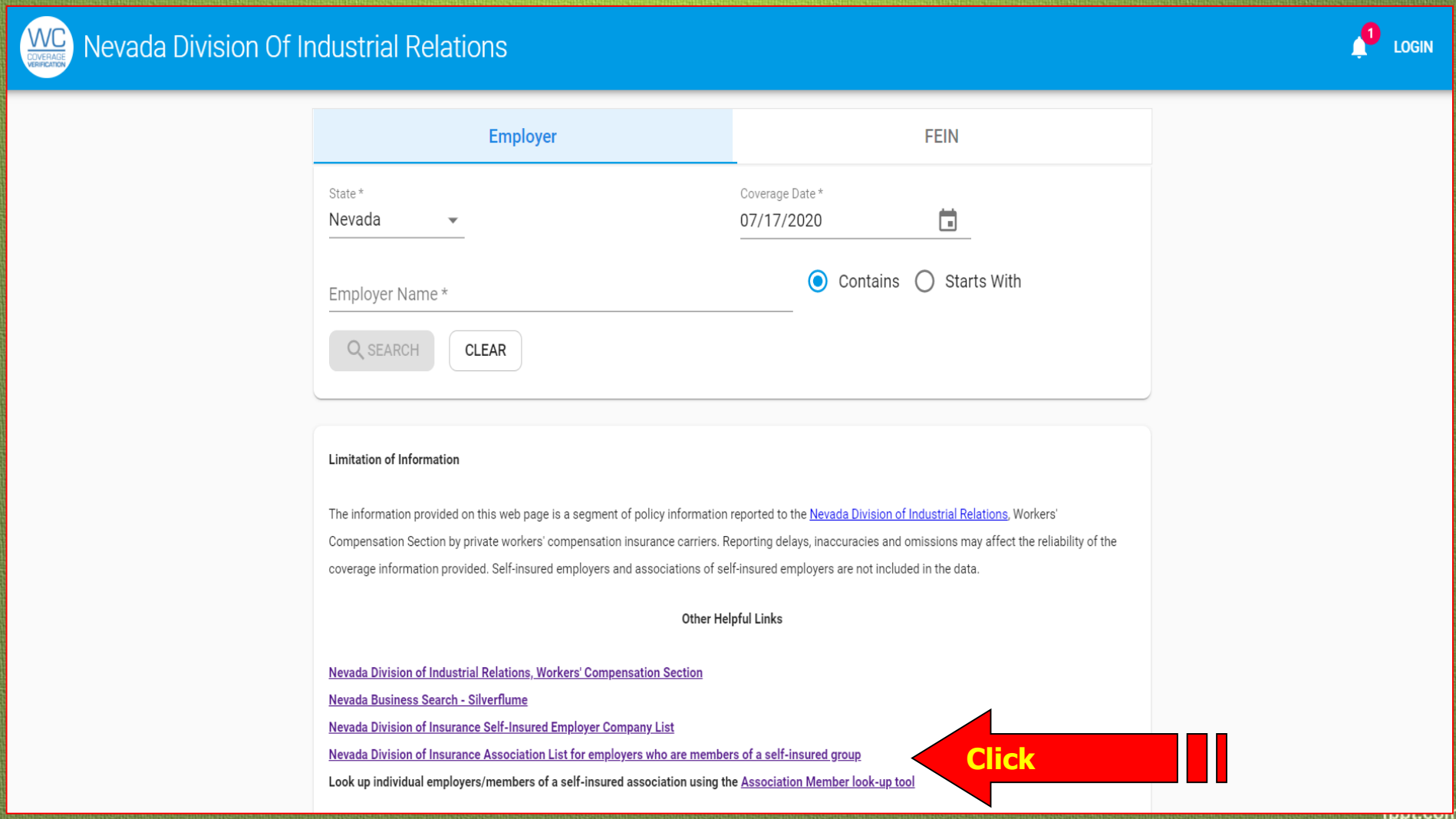
Association	Name	Date
Third Party Administrator	NELSON DAVISON ADMINISTRATORS INC	01-JUL-15

C of A 169

Employer
CITY OF HENDERSON
Mary Sexton
Workers' Compensation Analyst
240 Water StreetPO Box 95050, MSC137
Henderson NV 89009-5050
702-267-1922

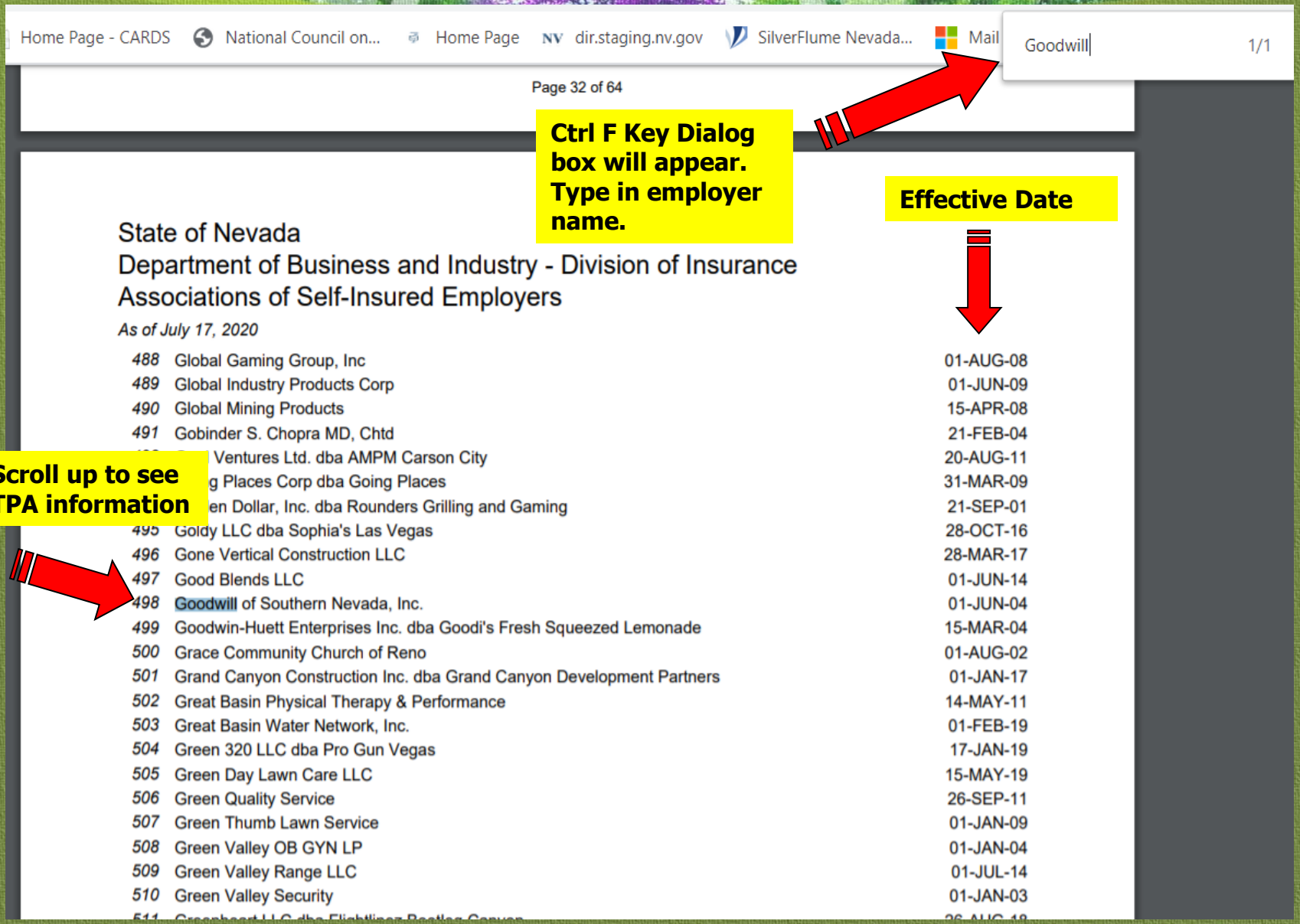
Ctl F Key Dialog box will appear type in employer name

Employer Association List

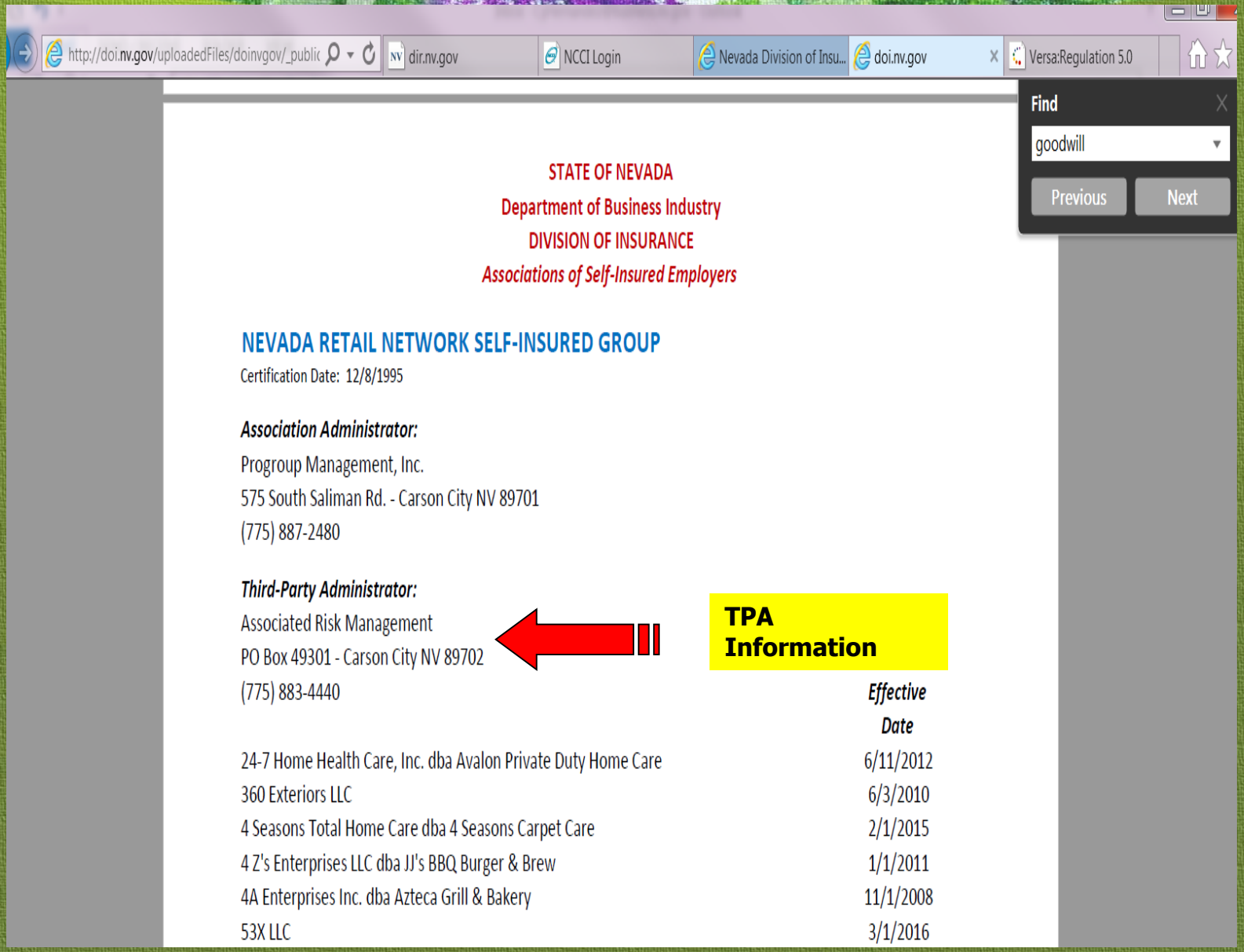


Association List

http://di.nv.gov/ins/f?p=112:15



Scroll Up for TPA Information



SilverFlume - Employer Info

- https://www.nvsilverflume.gov/home

SilverFlume
NEVADA'S BUSINESS PORTAL

NEVADA BUSINESS SEARCH

* Includes Trademarks, Trade Names, Service Marks, Reserved Names & Business Licenses

I WOULD LIKE TO SEARCH BY:

(•) Starts With ( ) Contains ( ) Exact Match ( ) All Words

Name: DELTA AIRLINES

BUSINESS ENTITY SEARCH CRITERIA

Entity Number:

NV Business ID Number:

Officer Name:

Registered Agent Name:

MARKS SEARCH CRITERIA

Mark Number:

Classification: -- Select --

Goods and Services:

Applicant Name:

ADVANCED SEARCH OPTIONS

(•) All ( ) Show Only Business Entity Information ( ) Show Only Mark Information

Type: -- Select --

Status: -- Select --

Search Clear

SilverFlume
NEVADA'S BUSINESS PORTAL

BUSINESSINFORMATION

ENTITY INFORMATION

ENTITY INFORMATION

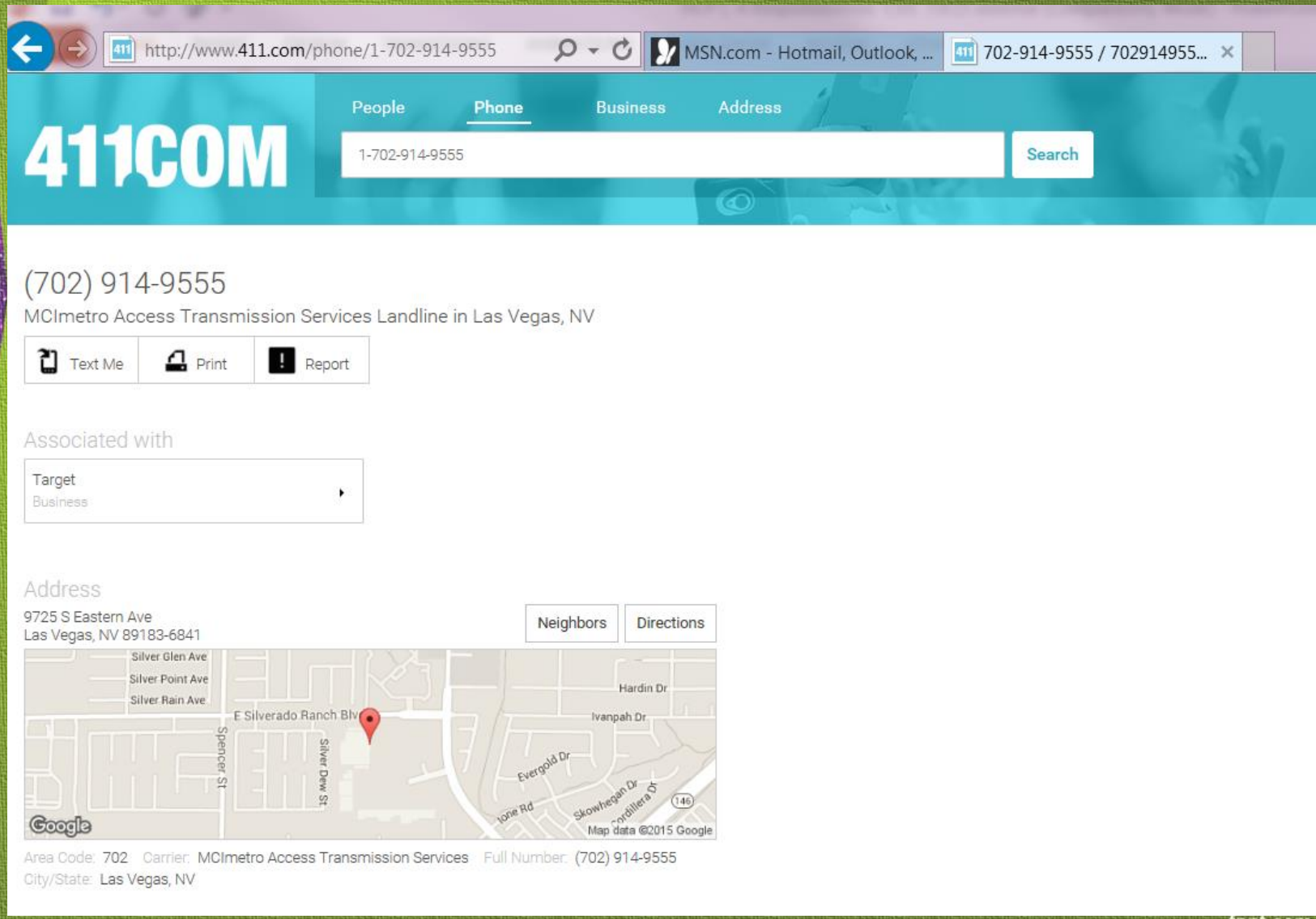
Entity Name:	DELTA AIR LINES, INC.	**Entity Number:**	C2468-1977
Entity Type:	Foreign Corporation (80)	**Entity Status:**	Active
Formation Date:	06/07/1977	**NV Business ID:**	NV19771003708
Termination Date:	Perpetual	**Annual Report Due Date:**	6/30/2020
Domicile Name:		**Jurisdiction:**	Delaware

REGISTERED AGENT INFORMATION

Name of Individual or Legal Entity:	CORPORATION SERVICE COMPANY	**Status:**	Active
CRA Agent Entity Type:		**Registered Agent Type:**	Commercial Registered Agent
NV Business ID:	NV19981229806	**Office or Position:**	
Jurisdiction:	DELAWARE		
Street Address:	112 NORTH CURRY STREET, Carson City, NV, 89703, USA	**Email Address:**	SOP@CSCGLOBAL.COM
Mailing Address:			
Individual with Authority to Act:	GEORGE MASSIH III	**Contact Phone Number:**	
Fictitious Website or Domain Name:			

Employer Info: 411

http://www.411.com/



Helpful Links

- State of Nevada – Division of Insurance: Tab – Self Insured: > Self-insured Company List > Association List: http://doi.nv.gov
- Nevada Secretary of State: http://nvsos.gov/
- Nevada Secretary of State: Silver Flume Business Portal https://www.nvsilverflume.gov/home
- Nevada State Contractors Board: Contractor Info & Searches > search by Company Name or Principal Name http://www.nvsbcontratpr.com/
- Business License Search – City of Henderson: https://dsconline.cityofhenderson.com/energov_prod/selfservice#/search
- Business License Search – City of Las Vegas: http://www3.lasvegasnevada.gov/Bus-license/Search.asp
- Business License Search – City of North Las Vegas: https://www.cityofnorthlasvegas.com/departments/community_development_and_compliance/business_license/BLLicStat.aspx

Helpful Links

- Business License Search – Reno, Sparks, Washoe and Douglas Counties:
  https://aca.accela.com/ONE/
- Business License Search – Town of Sparks:
  http://portal.cityofsparks.us/business_licenses/active
- Business License Search – Town of Pahrump: > Active Pahrump Business Licenses > PDF File
  http://www.pahrumpnv.org/pahrump-nevada/departments/pahrump-business-license/
- Business License Search – Reno
  http://dashboard.reno.gov/RenoBusinessLicenses/rdPage.aspx?rdReport=SearchPage
- Jurisdiction Locater – Clark County:
  http://gisgate.co.clark.nv.us/ziploc/
- DBA Search – Clark County: tab > Fictitious Firm Names
  http://www.clarkcountynv.gov/clerk/services/pages/fictitiousfirmnames.aspx
- DBA Search: Washoe County:
  http://www.washoecounty.us/clerks/dba_name_search.php
- On-line phone directory with reverse phone and address searches
  http://www.411.com
- Google
  http://www.google.com/

Steps For Obtaining Insurance Information

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

Step 5 If unable to locate TPA thru CVS or self-insured systems, contact employer. Document employer response

Step 6 If unable to locate coverage information after following above steps, call **WCS** Las Vegas at (702) 486-9080**.** If **WCS** unable to locate coverage over the telephone, you will be given a reference # and be directed to forward copy of Form C-4 and documentation to Las Vegas office for further investigation

Federal Government Claims

All **federal** government workers' comp claims, contact:

U.S. Department of Labor (DOL)
Office of Workers' Compensation Programs (OWCP)
P O Box 8300
London, KY 40742-8300
(415) 241-3300
http://www.dol.gov/owcp/

Medical Unit (MU) Contacts

C-4 Forms Las Vegas Office Only

*Proof of Coverage (POC) calls
(702) 486-9080

If requested by WCS staff **only**, email C-4 Forms
medunit@dir.nv.gov

Questions?

Please don't forget…

Complete the class evaluation online at http://dir.nv.gov/WCS/Training/