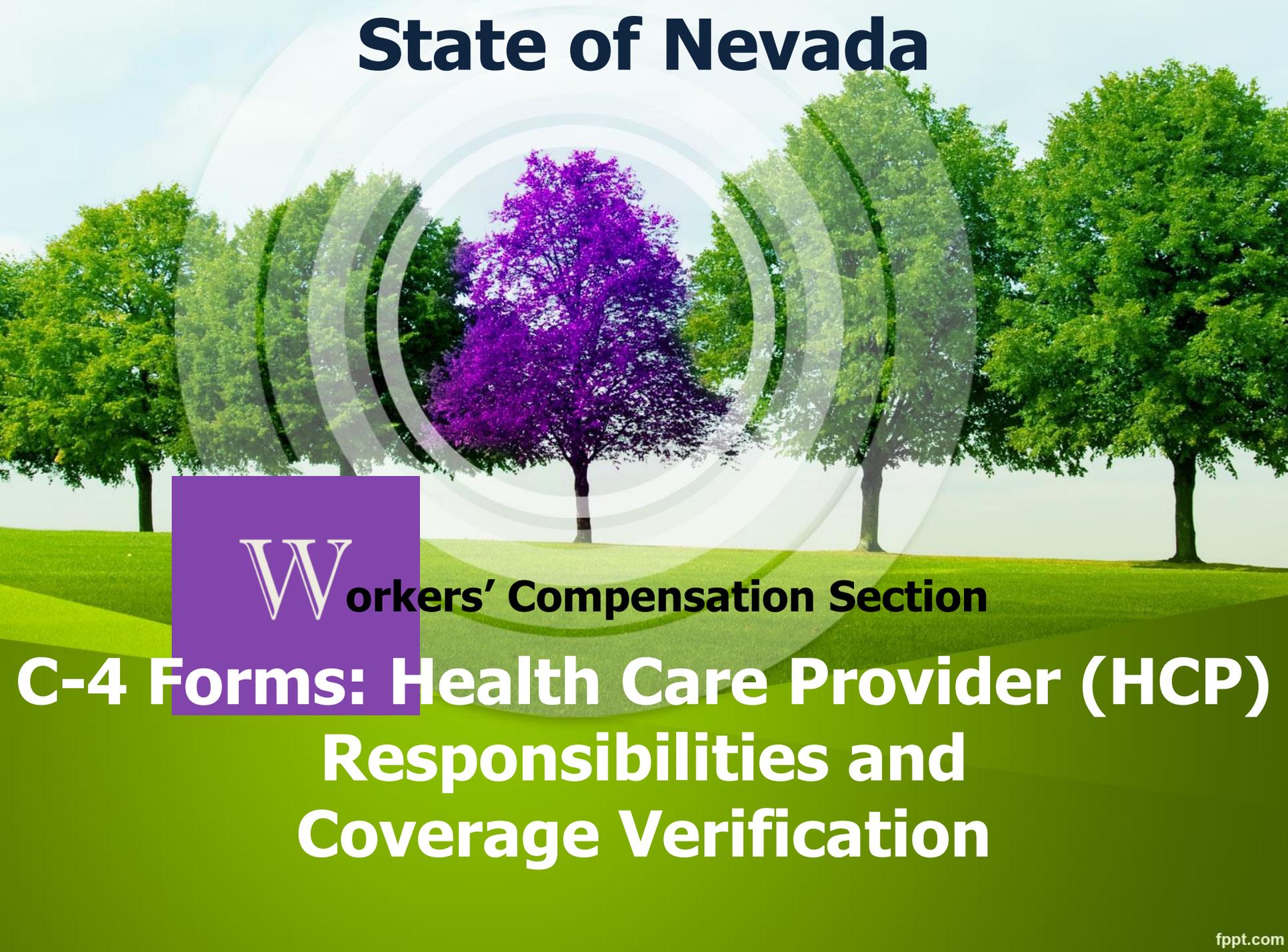


# State of Nevada

A landscape featuring several green trees on a grassy hill. In the center, there is a prominent tree with vibrant purple foliage. Overlaid on the scene is a large, semi-transparent circular graphic composed of several concentric rings, creating a ripple effect.

W

orkers' Compensation Section

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

# Every C-4 = Person Who Matters



PresenterMedia



# 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

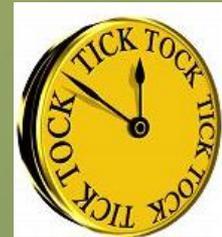
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| First Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | M.I.                                                        | Last Name              | Birthdate                                                                                                                                                                                                                                                                                  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                         | Claim Number (Insurer's Use Only)                                              |
| Home Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                             |                        | Age                                                                                                                                                                                                                                                                                        | Height                                                                                                                                                                                                                               | Weight                                                                         |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | State                                                       |                        | Zip                                                                                                                                                                                                                                                                                        | Telephone                                                                                                                                                                                                                            |                                                                                |
| Mailing Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                             |                        | City                                                                                                                                                                                                                                                                                       | State                                                                                                                                                                                                                                | Zip                                                                            |
| 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)<br>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                                                                                                                                                                                                  |                                                                                |
| <small>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.</small> |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Place                                                       | Employee's Signature   |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| <b>THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| 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?<br><input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain) |                                                                                |
| Hour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| Treatment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                        | Have you advised the patient to remain off work five days or more?<br><input type="checkbox"/> Yes Indicate dates: from _____ to _____<br><input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |                        |                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                      |                                                                                |
| Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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                                                                                                                                                                                                                               |                                                                                |

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

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

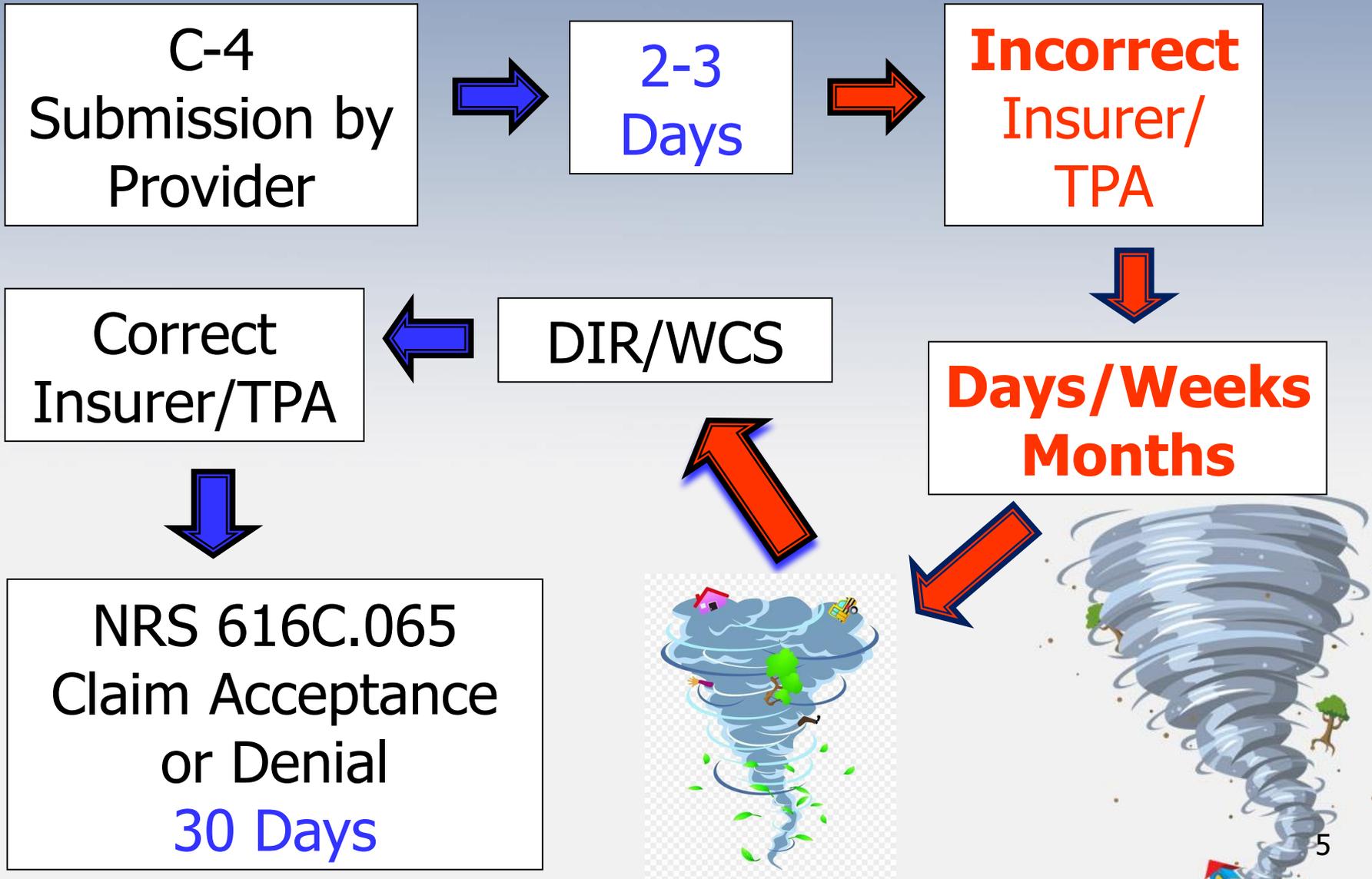


Transit Time  
**2-3 Days**



Insurer/TPA Approve  
or deny claim  
**30 DAYS**

# C-4 to Incorrect Insurer/TPA



# 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<br><input type="checkbox"/> M <input type="checkbox"/> F                   | Claim Number (Insurer's Use Only)         |
| Home Address                                                                                                                                       |                                       |                                  | Age                                                   | Height                                                                         | Weight                                    |
| City                                                                                                                                               | State                                 | Zip                              | Telephone                                             |                                                                                |                                           |
| Mailing Address                                                                                                                                    | City                                  | State                            | Zip                                                   | Primary Language Spoken                                                        |                                           |
| <b>INSURER</b>                                                                                                                                     |                                       | <b>THIRD-PARTY ADMINISTRATOR</b> |                                                       | 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)<br>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

**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.

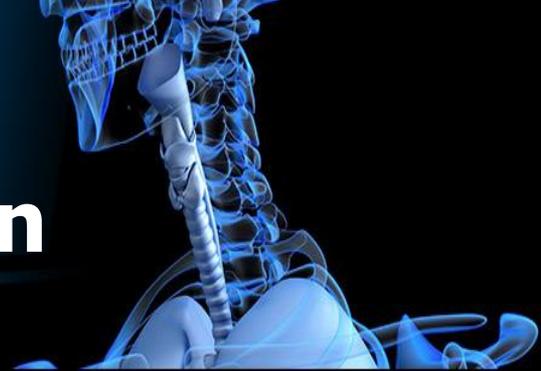
**For Assistance with Workers' Compensation Issues:** You may contact the State of Nevada Office for Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: <http://dhhs.nv.gov/Programs/CHA> E-mail: [cha@govcha.nv.gov](mailto:cha@govcha.nv.gov)

# D-2 Form

## Brief Description of Rights and Benefits

Must be provided to injured employee at time of treatment  
NRS 616C.095

# 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                                                                                                                                                                                                           | Diagnosis and Description of Injury or Occupational Disease | <p>Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain) |                    |
| Hour                                                                                                                                                                                                           |                                                             |                                                                                                                                                                                                                                          |                    |
| Treatment:                                                                                                                                                                                                     |                                                             | <p>Have you advised the patient to remain off work five days or more?</p> <input type="checkbox"/> Yes Indicate dates: from _____ to _____                                                                                               |                    |
| X-Ray Findings:                                                                                                                                                                                                |                                                             | <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty                                                                                         |                    |
| From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                             | <p>If modified duty, specify any limitations/restrictions: _____</p> <p>_____</p> <p>_____</p>                                                                                                                                           |                    |
| Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                  |                                                             |                                                                                                                                                                                                                                          |                    |
| Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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                                                                                                                                                                                                                                   |                    |

# 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](http://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/](http://dir.nv.gov/WCS/home/)

State of Nevada Department of Business & Industry  
**Industrial Relations (DIR)**

NV.gov Agencies Jobs

ENHANCED BY Google

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ADA Assistance PRINT

HOME LABOR STATS MECHANICAL MINES OSHA SCATS WORKERS' COMP CONTACT

**WELCOME TO WORKERS' COMPENSATION**

**FY21 Maximum Compensation**

return

?

Compensation

**What's Hot!**

- Hearings / Workshops / Meetings
- Current Newsletter
- Training
- Important Changes
- Join our Mailing List
- WCS Treating Panel Application/Instructions & Key Info
- PTD & Survivors' Benefits COLAs Information
- FY21 Maximum Compensation - Effective 7/1/2020
- New Actuarial Annuity Table Adopted, effective 7/1/2020
- Forms and Worksheets
- WCS Contacts
- Questions? - Please Use WCSHelp
- Public Records Policy

**COVERAGE VERIFICATION SERVICE**

**INJURED WORKERS**

**EMPLOYER COMPLIANCE**

**WORKERS' COMPENSATION NEVADA LAW**

**INSURER AND TPA REPORTING**

**CLAIMS AND REGULATORY DATA SYSTEM**

**CARDS**

# 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:

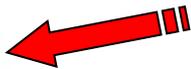
If an employer query does not produce any result(s) this may not mean that the employer does not have insurance or is operating in violation of state law. Coverage information may not be available or complete for all employers due to limitations with the policy information. Employer queries should be 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



| Employer                                                                   | FEIN                                                                        |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| State *<br>Nevada                                                          | Coverage Date *<br>07/17/2020                                               |
| Employer Name *                                                            | <input checked="" type="radio"/> Contains <input type="radio"/> Starts With |
| <input type="button" value="SEARCH"/> <input type="button" value="CLEAR"/> |                                                                             |



**Insert date of injury & employer name**



### Limitation of Information

The information provided on this web page is a segment of policy information reported to the [Nevada Division of Industrial Relations](#), Workers' Compensation Section by private workers' compensation insurance carriers. Reporting delays, inaccuracies and omissions may affect the reliability of the coverage information provided. Self-insured employers and associations of self-insured employers are not included in the data.

**Other helpful links**

[Nevada Division of Industrial Relations, Workers' Compensation Section](#)

[Nevada Business Search - Silverflume](#)

[Nevada Division of Insurance Self-Insured Employer Company List](#)

[Nevada Division of Insurance Association List for employers who are members of a self-insured group](#)

Look up individual employers/members of a self-insured association using the [Association Member look-up tool](#)



# 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



| Employer                              | FEIN                                                                        |
|---------------------------------------|-----------------------------------------------------------------------------|
| State *<br>Nevada                     | Coverage Date *<br>07/17/2020                                               |
| Employer Name *                       | <input checked="" type="radio"/> Contains <input type="radio"/> Starts With |
| <input type="button" value="SEARCH"/> | <input type="button" value="CLEAR"/>                                        |

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### Other Helpful Links

[Nevada Division of Industrial Relations, Workers' Compensation Section](#)

[Nevada Business Search - Silverflume](#)

[Nevada Division of Insurance Self-Insured Employer Company List](#)

[Nevada Division of Insurance Association List for employers who are members of a self-insured group](#)

Look up individual employers/members of a self-insured association using the [Association Member look-up tool](#)



# Self-Insured Employer Lookup

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

Department of Business and Industry

**Nevada Division of Insurance**



Help me find...

[Consumers](#)

[Health Insurance Rates](#)

[Healthcare Reform](#)

[Licensing](#)

[Insurers](#)

[Captive Insurers](#)

[News & Notices](#)

## Self-Insured Employer Lookup

Lookup By  **AutoComplete**  Name Search  C of A  ?

Employer Name:



*Can't find the Employer you are looking for? Try using the Name Search*

[Find Employer](#)

[Go to Association Member Lookup](#)

# Self-Insured Association Member Lookup

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

Department of Business and Industry  
Nevada Division of Insurance

Home Facebook Search Help me find...

[Consumers](#) [Health Insurance Rates](#) [Healthcare Reform](#) [Licensing](#) [Insurers](#) [Captive Insurers](#) [News & Notices](#)

## Self-Insured Employer Association Member Lookup

Lookup By  **AutoComplete**  Name Search  Doing Business as Name

Employer Name:

*Can't find the Company you are looking for? Try using the Name Search*

[Find Employer Member](#)

[Go to Employer Lookup](#)



# Self-insured Contact Information

Find ×  
cedar enter  
Previous Next

Ctrl F Key Dialog box will appear type in employer name

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-     |
| <b>C of A</b><br>199      | <b>Employer</b><br><b>CEDAR ENTERPRISES</b><br>Kia Summers<br>Human Resources Representative<br>1328 Dublin Road Suite 300<br>Columbus OH 43215<br>614-737-7808                 |             |
| <b>Association</b>        | <b>Name</b>                                                                                                                                                                     | <b>Date</b> |
| Third Party Administrator | SIERRA NEVADA ADMINISTRATORS INC                                                                                                                                                | 11-SEP-13   |
| Subsidiary                | WENDY'S OF LAS VEGAS, INC.                                                                                                                                                      | 01-JAN-04   |
| <b>C of A</b><br>130131   | <b>Employer</b><br><b>CHURCHILL COUNTY SCHOOL DISTRICT</b><br>Phyllis Dowd<br>Director of Business Services<br>690 S MAINE ST<br>FALLON NV 89408-3807<br>775-428-7220           |             |
| <b>Association</b>        | <b>Name</b>                                                                                                                                                                     | <b>Date</b> |
| Third Party Administrator | NELSON DAVISON ADMINISTRATORS INC                                                                                                                                               | 01-JUL-15   |
| <b>C of A</b><br>169      | <b>Employer</b><br><b>CITY OF HENDERSON</b><br>Mary Sexton<br>Workers' Compensation Analyst<br>240 Water Street PO Box 95050, MSC137<br>Henderson NV 89009-5050<br>702-267-1022 |             |

**TPA  
Information**

# Employer Association List



| Employer                                | FEIN                                                                                                              |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| State *<br>Nevada ▾                     | Coverage Date *<br>07/17/2020  |
| Employer Name *<br><input type="text"/> | <input checked="" type="radio"/> Contains <input type="radio"/> Starts With                                       |
| <input type="button" value="SEARCH"/>   | <input type="button" value="CLEAR"/>                                                                              |

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# Association List

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

Home Page - CARDS

National Council on...

Home Page

NV dir.staging.nv.gov

SilverFlume Nevada...

Mail

Goodwill

1/1

Page 32 of 64

**Ctrl F Key Dialog box will appear. Type in employer name.**

**Effective Date**

State of Nevada  
Department of Business and Industry - Division of Insurance  
Associations of Self-Insured Employers

As of July 17, 2020

|     |                                                                      |           |
|-----|----------------------------------------------------------------------|-----------|
| 488 | Global Gaming Group, Inc                                             | 01-AUG-08 |
| 489 | Global Industry Products Corp                                        | 01-JUN-09 |
| 490 | Global Mining Products                                               | 15-APR-08 |
| 491 | Gobinder S. Chopra MD, Chtd                                          | 21-FEB-04 |
| 492 | Goetz Ventures Ltd. dba AMPM Carson City                             | 20-AUG-11 |
| 493 | Going Places Corp dba Going Places                                   | 31-MAR-09 |
| 494 | Golden Dollar, Inc. dba Rounders Grilling and Gaming                 | 21-SEP-01 |
| 495 | Goldy LLC dba Sophia's Las Vegas                                     | 28-OCT-16 |
| 496 | Gone Vertical Construction LLC                                       | 28-MAR-17 |
| 497 | Good Blends LLC                                                      | 01-JUN-14 |
| 498 | <b>Goodwill</b> of Southern Nevada, Inc.                             | 01-JUN-04 |
| 499 | Goodwin-Huett Enterprises Inc. dba Goodi's Fresh Squeezed Lemonade   | 15-MAR-04 |
| 500 | Grace Community Church of Reno                                       | 01-AUG-02 |
| 501 | Grand Canyon Construction Inc. dba Grand Canyon Development Partners | 01-JAN-17 |
| 502 | Great Basin Physical Therapy & Performance                           | 14-MAY-11 |
| 503 | Great Basin Water Network, Inc.                                      | 01-FEB-19 |
| 504 | Green 320 LLC dba Pro Gun Vegas                                      | 17-JAN-19 |
| 505 | Green Day Lawn Care LLC                                              | 15-MAY-19 |
| 506 | Green Quality Service                                                | 26-SEP-11 |
| 507 | Green Thumb Lawn Service                                             | 01-JAN-09 |
| 508 | Green Valley OB GYN LP                                               | 01-JAN-04 |
| 509 | Green Valley Range LLC                                               | 01-JUL-14 |
| 510 | Green Valley Security                                                | 01-JAN-03 |
| 511 | Greenheart LLC dba Fishliner Boatles Canyon                          | 26-AUG-19 |

**Scroll up to see TPA information**

# Scroll Up for TPA Information

STATE OF NEVADA  
Department of Business Industry  
DIVISION OF INSURANCE  
*Associations of Self-Insured Employers*

**NEVADA RETAIL NETWORK SELF-INSURED GROUP**  
Certification Date: 12/8/1995

**Association Administrator:**  
Progroup Management, Inc.  
575 South Saliman Rd. - Carson City NV 89701  
(775) 887-2480

**Third-Party Administrator:**  
Associated Risk Management  
PO Box 49301 - Carson City NV 89702  
(775) 883-4440

**TPA Information**

|                                                               | <i>Effective Date</i> |
|---------------------------------------------------------------|-----------------------|
| 24-7 Home Health Care, Inc. dba Avalon Private Duty Home Care | 6/11/2012             |
| 360 Exteriors LLC                                             | 6/3/2010              |
| 4 Seasons Total Home Care dba 4 Seasons Carpet Care           | 2/1/2015              |
| 4 Z's Enterprises LLC dba JJ's BBQ Burger & Brew              | 1/1/2011              |
| 4A Enterprises Inc. dba Azteca Grill & Bakery                 | 11/1/2008             |
| 53X LLC                                                       | 3/1/2016              |

# SilverFlume - Employer Info

▶ <https://www.nvsilverflume.gov/home>



REGISTER | LOGIN

Search nvsilverflume.gov

HOME

DASHBOARD

DOCUMENTS

## Nevada's First Stop For Business Registration

A Service provided by the  
Secretary of State, Barbara K. Cegavske

### NEW BUSINESS

- [New Business Checklist](#)
- [Start Your Business](#)
- [Get a State Business License](#)
- [Reserve a Name](#)

### EXISTING BUSINESS

- [Renew a State Business License](#)
- [License](#)
- [File Annual or Amended List](#)
- [Cancel, Dissolve, Terminate](#)
- [Reinstatements & Revivals](#)
- [Renew Local License<sup>\(s\)</sup>](#)
- [Make a Tax Payment<sup>\\*</sup>](#)
- [More >](#)

### OTHER BUSINESS SERVICES

- [Uniform Commercial Code](#)
- [Notary](#)
- [Trademarks/Service Marks](#)
- [Manage Online Trust Account](#)
- [Copy Requests](#)
- [Apostille & Certificate](#)
- [Verification](#)
- [More >](#)

### QUICK LINKS

- [Frequently Asked Questions](#)
- [Nevada Secretary of State Divisions](#)

### ADDITIONAL RESOURCES

- [Business Entity Search](#)
- [Business Resource Center](#)
- [Regulatory and Licensing Boards](#)
- [Cities and Counties](#)



## 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:



### BUSINESS ENTITY SEARCH CRITERIA

Entity Number:

NV Business ID Number:

Officer Name:

Registered Agent Name:

### MARKS SEARCH CRITERIA

Mark Number:

Classification:

Goods and Services:

Applicant Name:

### ADVANCED SEARCH OPTIONS

All    Show Only Business Entity Information    Show Only Mark Information

Type:

Status:

Search

Clear



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/>



# 411COM

People Phone Business Address

1-702-914-9555

## (702) 914-9555

MCImetro Access Transmission Services Landline in Las Vegas, NV

### Associated with

Target  
Business

### Address

9725 S Eastern Ave  
Las Vegas, NV 89183-6841



Area Code: 702 Carrier: MCImetro Access Transmission Services Full Number: (702) 914-9555  
City/State: Las Vegas, NV

# 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](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.asp](https://www.cityofnorthlasvegas.com/departments/community_development_and_compliance/business_license/BLLicStat.asp)  
X

# 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](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 Locator – 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](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](mailto:medunit@dir.nv.gov)



# Questions?



# Please don't forget...

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

HOME LABOR STATS MECHANICAL MINES OSHA SCATS WORKERS' COMP CONTACT

### Workers' Comp

Employers

Insurers

Medical Providers

Insurer-TPA Reporting

Injured Workers

Subsequent Injury

Hearings

Important Changes

Newsletter Archives

### Training

Forms and Worksheets

### TRAINING

- [2020 Training Schedule](#)
- [Training Registration Form](#)

#### Delving into the D-35

- [D35 Training Presentation](#)
  - [October 28, 2020 D-35 Packet](#)
  - [Body Part Code](#)
  - [D-35 Error Fax Cover Sheet](#)

#### COLAs for Permanent Total Disability & Survivors' Benefits Training Material

- [COLAs for Permanent Total Disability & Survivors' Benefits Training Material](#)
  - [PTD Verification Form Draft](#)
  - [Survivors Verification Form Draft](#)
  - [2019 COLA Legislation- Notice to Insurers and TPAs \(11/19\)](#)

#### Senate Bill 381 (2019) Implementation Training

- [Senate Bill 381](#)

#### Training Documents

- [WCS Basic Orientation Training Presentation 2020](#)
- [WCS Basic Orientation Training Packet](#)
- [WCS Fall Newsletter](#)
- [C-4 and Coverage Verification Training Presentation](#)
- [Medical Billing Presentation](#)
- [WCS Employer Compliance Presentation](#)
- [Training Brochure](#)

#### 2020 Training Surveys

- [C-4 Forms: Health Care Provider \(HCP\) Responsibilities and Coverage Verification](#)
- [Medical Billing](#)

