



Sedgwick Claims Kit Nevada



P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275



Dear Insured:

We would like to welcome you as a policyholder of Falls Lake National Insurance Company. Sedgwick is your Claims Administrator and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachment.

Where do I report a claim?

- **Phone:** 855-728-5277 (855-7ATLAS7) OR;
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com OR;
- **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

- **Website:** www.sedgwickproviders.com

Sedgwick Claim Kit Attachments:

- Notice to Employees (D-1) – **MUST BE POSTED**
- Employer's First Report of Injury Form (C-3)
- Notice of Injury or Occupational Disease (C-1) – **MUST BE PROVIDED TO INJURED EMPLOYEES**
- Employee's Claim for compensation/Report of Initial Treatment (C-4) - **MUST BE PROVIDED TO INJURED EMPLOYEES**
- Employee Rights (D-2) - **MUST BE PROVIDED TO INJURED EMPLOYEES**
- Choice of Physicians form (D-52)
- Mileage form (D-26(1))
- Authorization for Release and Use of Medical Information (D-36)
- Express Scripts First Fill Temporary Pharmacy Card

Need a loss run?

- **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team @ Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- **Phone:** 866-738-9201
- **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

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 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. NAIW is an independent state agency and is not affiliated with any insurer. 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 Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: <http://govcha.state.nv.us>, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

MCO/Health Care Provider: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER	Employer's Name		Nature of Business (mfg., etc.)		FEIN		OSHA Log #												
	Office Mail Address			Location . . . If different from mailing address			Telephone												
	City		State		Zip		INSURER		THIRD-PARTY ADMINISTRATOR										
EMPLOYEE	First Name		M.I.		Last Name		Social Security		Birthdate		Age		Primary Language Spoken						
	Home Address (Number and Street)					Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed											
	City		State		Zip		Was the employee paid for the day of injury? (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No				How long has this person been employed by you in Nevada?								
	In which state was employee hired?			Employee's occupation (job title) when hired or disabled					Department in which regularly employed:										
	Telephone		Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No					Was employee in your employ when injured or disabled by occupational disease (O/D)? <input type="checkbox"/> Yes <input type="checkbox"/> No											
ACCIDENT OR DISEASE	Date of Injury (if applicable)		Time of injury (Hours; Minute AM/PM) (if applicable)			Date employer notified of injury or O/D			Supervisor to whom injury or O/D reported										
	Address or location of accident (Also provide city, county, state) (if applicable)							Accident on employer's premises? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No											
	What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)																		
	How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.																		
INJURY OR DISEASE	Specify machine, tool, substance, or object most closely connected with the accident (if applicable)					Witness			Was there more than one person injured in this accident? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No										
	Part of body injured or affected			If fatal, give date of death		Witness													
	Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)					Witness			Will you have light duty work available if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No										
	If validity of claim is doubted, state reason					Did employee return to next scheduled shift after accident? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No													
	Treating physician/chiropractor name					Location of Initial Treatment			Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No										
	IMPORTANT		How many days per week does employee work?			From		<input type="checkbox"/> am <input type="checkbox"/> pm		To		<input type="checkbox"/> am <input type="checkbox"/> pm		Last day wages were earned					
Scheduled days off		S <input type="checkbox"/>		M <input type="checkbox"/>		T <input type="checkbox"/>		W <input type="checkbox"/>		T <input type="checkbox"/>		F <input type="checkbox"/>		S <input type="checkbox"/>		Rotating <input type="checkbox"/>		Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IMPORTANT LOST TIME INFO	Date employee was hired			Last day of work after injury or disability			Date of return to work			Number of work days lost									
	Was the employee hired to work 40 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No			If not, for how many hours a week was the employee hired?			Did the employee receive unemployment compensation any time during the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know												
	For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.																		
	Pay period ends on: <input type="checkbox"/> SUN <input type="checkbox"/> TUE <input type="checkbox"/> THUR <input type="checkbox"/> SAT <input type="checkbox"/> MON <input type="checkbox"/> WED <input type="checkbox"/> FRI			Employee is paid: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER <input type="checkbox"/> BI-WKLY <input type="checkbox"/> SEMI-MONTHLY			On the date of injury or disability the employee's wage was: \$ _____ per <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> Mo												
<p>For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us</p>																			
Insurer Use Only	I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.					Employer's Signature and Title			Date										
	Claim is: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 rd Party					Deemed Wage			Account No.			Class Code							
Claims Examiner's Signature					Date			Status Clerk			Date								

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee		Social Security Number	Telephone Number	
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)		
What is the nature of the injury or occupational disease?		List any body parts involved:		
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)				
Names of witnesses:				
Did the employee leave work because of the injury or occupational disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when (date and time)?	Has the employee returned to work? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when (date and time)?	
Was first aid provided? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, by whom?	Name and address of treating physician, if applicable or known		
Did the accident happen in the normal course of work? (if applicable) <input type="checkbox"/> YES <input type="checkbox"/> NO				
Was anyone else involved? <input type="checkbox"/> YES <input type="checkbox"/> NO	Names of others involved			

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature

Date

Signature of Injured or Disabled Employee

Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

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Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT

FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED								
First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)			
Home Address			Age	Height	Weight	Social Security Number		
City	State		Zip		Telephone			
Mailing Address	City		State		Zip			
						Primary Language Spoken		
INSURER			THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employer's Name/Company Name					Telephone			
Office Mail Address (Number and Street)								
Date of Injury (if applicable)	Hours Injury (if applicable) am pm		Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported			
Address or Location of Accident (if applicable)								
What were you doing at the time of the accident? (if applicable)								
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)								
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)			
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected					
<p style="font-size: small; color: red;">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.</p>								
Date	Place		Employee's Signature					
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT								
Place			Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease			<p style="color: red;">Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)</p>				
Hour								
Treatment:			<p style="color: red;">Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____</p>					
X-Ray Findings:								
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <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					

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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State of Nevada
Department of Business & Industry
Division of Industrial Relations
Workers' Compensation Section

**ALTERNATIVE CHOICE OF PHYSICIAN or CHIROPRACTOR
(NRS 616C.090)**

A list of the Panel of Treating Physicians or Chiropractors, or those health care providers, with whom your insurer has contracted, can be obtained from your insurer or third-party administrator upon written request. Your insurer or third-party administrator has 3 working days to provide you the list pursuant to NAC 616C.030.

If within the **first 90 days after the date of injury**, you are not satisfied with the **first** treating physician or chiropractor and

Your insurer **has entered** into a contract with a managed care organization or with health care providers; you must select an alternative physician or chiropractor according to the terms of the contract. This selection may be made without the prior approval of the insurer. If after choosing your physician or chiropractor, you move to a county not serviced by the contracted managed care organization or health care providers and the insurer deems it impractical for you to continue treating with the physician or chiropractor, you must choose a treating physician or chiropractor who has agreed to the terms of the contract unless the insurer authorizes you to choose another physician or chiropractor;

or

Your insurer **has not entered** into a contract with an organization for managed care, or with health care providers, you may select an alternative physician or chiropractor from the Panel of Treating Physicians and Chiropractors.

NOTICE: Any further changes in your treating physician or chiropractor must be in writing and approved by the insurer. If, at any time, you are dissatisfied with a physician or chiropractor selected by yourself, the insurer, managed care organization, or health care provider, a change may be made by submitting a written request to the insurer indicating the name of the alternate physician or chiropractor. The insurer shall approve or deny this request within ten (10) days after receipt of the written request or it shall be deemed approved. You will receive written notification if the insurer denies this request which will include the reason for the denial and appeal rights.

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number		
Present Address (P.O. Box, Apt. No., Street)			Social Security Number		
City	State	Zip	Date of Injury		
Residence at time of injury:			(For Insurer's Use Only) <input type="checkbox"/> Approved _____ <input type="checkbox"/> Disapproved Initials & Date		

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			

TOTAL MILES:

Total of _____ Miles X 2 @ \$ _____ . ____ per Mile =

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

Injured Employee's Signature

Date

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

- (a) His residence to the place where he receives medical care; or
- (b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

- (a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or
- (b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

- (a) That allowed for state employees; or
- (b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

- (a) The per diem allowance authorized for state employees; or
- (b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

NAC 616C.156 Limitations on reimbursements.

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than \$250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to \$1,000. If the amount of the benefit or payment is \$250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to \$5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

Request for Additional Medical Information And Medical Release

(Pursuant to NRS 616C.177 & 616C.490(4))

Injured Employee's Name: _____

Claim Number: _____ Social Security Number: _____

Injured Employee's Address: _____

Injury/Occupational Disease Date: _____ Date this Notice Printed: _____

Insurer's Name: _____ Employer: _____

Insurer's Address: _____ Employer's Address: _____

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. This renews the release you signed on your C-4 form at the time your claim was submitted to your insurer. Failure to fully complete and return this form to your claims agent in a timely manner could affect your benefits or delay the resolution of your claim.

Prior History Information

Please check the appropriate box below and provide the information requested.

I have no prior conditions, injuries or disabilities of which I am aware, that might affect the disposition of the claim referenced above. (If you checked this box, no further information is needed at this point)

I have a prior condition, injury or disability that could affect the disposition of the claim referenced above. This can include birth defects, prior surgeries, injuries, etc., whether work related or not. (If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary to fully explain the condition)

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.

Signature

Date

Workers' Compensation Temporary Prescription ID Card

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

»» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____

MM/DD/YYYY

Group #: GJC6200 _____

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First

M

Last

Street Address or PO Box

City

State

ZIP

Employer Name



Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	Shaw's
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	Stop & Shop
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	Target
Bi-Lo	Fred's	Osco	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
BJ's Wholesale	Giant	Markets	The Pharm
Club	Giant Eagle	Pamida	Thrifty White
Brooks	Giant Foods	Park Nicollet	Times
Brookshire Brothers	Hannaford	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	Price Chopper	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
Costco	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	Rite Aid	Waldbaums
CVS	Keltsch	Rosauers	Walgreens
D&W	Kerr	Rx Express	Wal-Mart
Dahl's	Kmart	RXD	Wegmans
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	Sam's Club	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	



EXPRESS SCRIPTS®