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

This form must be completed IN FULL and SIGNED to be processed

INDEX OF CLAIMS SYSTEM

CLAIM REGISTRATION/UPDATE/REQUEST DOCUMENT

REGISTRATION ☐ **UPDATE** ☐ **REQUEST** ☐

REQUESTOR IS: ☐ Association of Self-Insured Employer ☐ Self-Insured Employer
☐ Private Insurer ☐ Third-Party Administrator

Requestor Name _____ FEIN # _____

INJURED EMPLOYEE SSN: _____ Date Submitted: _____

Injured Employee Name: _____
Last First Middle Initial

Sex: **M**ale ☐ **F**emale ☐ Birthdate: _____ Claim Type: **L**ost Time ☐ **M**edical Only ☐

Claim Number: _____ Injury or Occupational Disease Date: _____

Date Claim Closed _____ Closure Pursuant To: ☐ NRS 616C.235(1) Date ReOpened _____
☐ NRS 616C.235(2)

Third-Party Administrator: _____ **FEIN #:** _____
Self-Insured Employer: _____ **FEIN #:** _____
Assoc. of Self-Insured Employer: _____ **FEIN #:** _____
Private Insurer: _____ **FEIN #** _____
Private Insurer Address: _____
Street City State Zip
Policy Effective Date: _____ **Policy Expiration Date:** _____
Employer: _____ **FEIN #** _____
Address: _____
Street City State Zip

BODY PART CODE	BODY PART DESCRIPTION	**L**eft, **R**ight or **B**ilateral	BODY PART CODE	BODY PART DESCRIPTION	**L**eft, **R**ight or Bilateral

I hereby certify that the information contained on this form is true and correct. I also certify that I am a duly authorized representative of the requestor.

Signature _____ Date _____