

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Please check one only: INITIAL REPORT UPDATE REPORT

ALL REPORTS (Complete this section for INITIAL REPORTS AND UPDATES)

Date Report Submitted (to WCS): _____	
Insurer Name: _____	
Insurer Certificate Number: _____	Insurer FEIN: _____
Employer Name: _____	
Claim Number: _____	
Submitted by: _____	
Individual Name and Title (please print)	
Company: _____	Insurer <input type="checkbox"/>
Address: _____	TPA <input type="checkbox"/>
City, State, Zip: _____	Other <input type="checkbox"/>
_____ Telephone	_____ E-mail Address

INITIAL & UPDATE REPORTS (Report within 30 days of acceptance/denial or any changes to the claim)

Date Claim (C-4) Received: _____	Date of Injury: _____
Claim Disposition: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied	Date Accepted/Denied: _____
Reason for Acceptance/Denial: _____	
Statute/Reg. Citation: _____	
Estimated Medical Costs of Claim: \$ _____	
Description of Nature of Claim: _____	
NATURE OF CLAIM CODE (Select from the IAIABC Codes below):	
<input type="checkbox"/> 61 ASBESTOSIS, LUNG DISEASE FROM INHALED ASBESTOS	<input type="checkbox"/> 73 CONTAGIOUS DISEASE, UNSPECIFIED
<input type="checkbox"/> 62 BLACK LUNG, CHRONIC LUNG DISEASE/COAL	<input type="checkbox"/> 74 CANCER
<input type="checkbox"/> 63 BYSSINOSIS, PNEUMOCONIOSIS FROM COTTON, FLAX	<input type="checkbox"/> 75 AIDS
<input type="checkbox"/> 64 SILICOSIS, PNEUMOCONIOSIS FROM INHALED SILICA	<input type="checkbox"/> 79 HEPATITIS C
<input type="checkbox"/> 65 RESPIRATORY DISORDERS, GASSES, FUMES, CHEMICALS, ETC.	<input type="checkbox"/> 03 ANGINA PECTORIS, CHEST PAIN
<input type="checkbox"/> 60 DUST DISEASE, ALL OTHER PNEUMOCONIOSIS	<input type="checkbox"/> 41 MYOCARDIAL INFARCTION, HEART DISEASE/CONDITIONS
	<input type="checkbox"/> 00 OTHER BE SPECIFIC _____
Symptoms/Exposure Only: (No Confirmed Diagnosis) <input type="checkbox"/> YES <input type="checkbox"/> NO	

UPDATE REPORTS ONLY (Report within 30 days of appeal, closure, reopening, or confirmed diagnosis)

Appeal(s) of Acceptance/Denial:	
Date Appeal Filed: _____	
Appeal <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> Other _____ Hearing Date: _____	
Decision: <input type="checkbox"/> Affirmed <input type="checkbox"/> Modified <input type="checkbox"/> Reversed <input type="checkbox"/> Remanded	
Decision Date: _____	
Diagnosis Confirmed: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did Nature of Claim Change? <input type="checkbox"/> YES - NEW CODE # _____ <input type="checkbox"/> NO	
Additional Information/Explanation (include clarification of activity reported): _____ _____	
Initial Claim Closure Date: _____	
Date Claim Reopened (if applicable): _____	
Subsequent Claim Closure Date (if applicable): _____	