Insert insurer or self-insured employer name, service company name (if applicable), and the mailing address and phone number of the location responsible for processing the claim.

INSURER'S REPORT

DO NOT USE THIS FORM FOR OWN MOTION CLAIMS – USE FORM 3501

WCD file no.:

Worker's legal name: First MI Last	Date of injury (month-day-year):
Address:	Social Security no.
City: State: ZIP:	Insurer's claim no.:
Insured policy holder name as it appears on policy:	Policy no.
Covered employer's legal name, if different from above:	Wrap-up project name, if applicable:
Covered employer's address: City:	State: ZIP:

1 Status of claim at the time of filing this report. *Check one in each column.*

☐ (A) Accepted ☐ (X) Denied ☐ (X) Partially denied	☐ (D) Disabling ☐ (N) Nondisabling ☐ (Y) Fatality Date of death:	☐ (Y) Occupational disease ☐ (N) Injury	☐ (O) Original injury ☐ (R) Aggravation

2 Reason for filing this form (At least one reason must be checked.)

Complete on all reports.

Attach forms 801 and 827 if not previously sent.

Mo. – Day – Yr.

- ☐ (F) **First report** of claim **(Enter date employer first knew of claim - if not reported on attached 801.)** →
  - ☐ **Check if** claim was previously accepted as nondisabling **(Attach acceptance letter; enter date of acceptance.)**
- ☐ (T) **First report** of new or omitted condition reopening (Check even if litigation ordered acceptance.)
- ☐ (R) **First report** of claim for **aggravation** **(Enter date insurer received claim for aggravation.)** →
- ☐ (V) **First report** of reopening for **voc. training** **(Enter first date actively engaged in training program.)**
- ☐ (L) **First report** since **a litigation order or stipulated agreement resulted in a change in the acceptance or disability status** **(Enter date of order.)** →
- ☐ (S) Change in **acceptance** or **disability** status **(Attach copy of letter sent to worker explaining changes.)**
- ☐ (P) Notice of partial denial of accepted claim **(Attach copy of denial letter.)**
- ☐ (C) **Correction** of wage, SSN, date employer first knew of claim, TTD rate, etc. **(Explain below.)**
- ☐ (O) **Other (Explain below.)**
- ☐ (M) **MCO enrollment** after claim acceptance **(Complete MCO section.)**

3 Weekly TTD rate based on paid-through date.

$ | Paid from (this open period): | Paid through: | OR ☐ No compensation due. **(Skip to #6; explain below).**

4 Weekly wage *Complete on first reports and wage changes.*

$ | Explain weekly wage computation if based on information other than that shown on 801, or if 801 is not with first report.

5 Was first payment of compensation paid timely? *Complete only on first reports.*

☐ Yes ☐ No — If payment was made, provide date of first payment.

OR ☐ Salary continued (self-insured employer). ☐ No compensation due. (Explain below.)

6 Was claim accepted or denied timely? *Complete on acceptance or denial of claim only.*

☐ Yes ☐ No — (***Attach*** *copy of acceptance or denial letter.)*

FOR WCD USE ONLY

7 Is worker enrolled in an MCO? *Complete unless enrollment was previously reported.*

☐ Yes ☐ No — If "Yes," provide date of enrollment.

MCO no.:

Explanations:

FOR WCD USE ONLY

I certify this information is true and correct and that all dates required are accurate.

X _____ _____ _____

Insurer's representative | *Phone no. of representative* | *Date mailed to WCD*

(See OAR 436-060-0011 and WCD Bulletin No. 237 for additional instructions, and OAR 438-012-0001(4), ORS 656.278, and Bulletin 195 for Own Motion claims.)
Contact the Claims Quality Control at 503-947-7810, if you have questions.

1502

General instructions for completing and filing Form 1502

Header:
Provide the actual name of the insurance company or self-insured employer responsible for the claim, the service company (if applicable), and claims processing address and phone number.

Claim identifiers:
Provide the worker's name, address, Social Security number (SSN), date of injury, and claim number. The SSN is required under OAR 436-060, unless the insurer is unable to obtain the worker's SSN. If the SSN cannot be obtained, the insurer must state this on the Form 1502 where the SSN is reported.

Insured policy holder:
Provide name of insured entity that purchased the coverage as it appears on the insurance policy.

Covered employer's legal name:
Provide the legal name of the employer as it appears on the insurance policy (not doing business as name).

Policy number:
Provide the policy number as it appears on the insurance policy, unless the employer is self-insured or the claim is a noncomplying employer claim.

Wrap-up project name:
Provide the wrap-up project name, if the claim is from a wrap-up project.

Section 1: Status of claim
Report the status of the claim at the time of filing Form 1502 with the division by checking only one item in each of the four columns.

"Original Injury":
(a) a claim that has not been closed by a Notice of Closure; or
(b) a claim that has been closed by a Notice of Closure, but reopened for a new or omitted medical condition or for vocational assistance only.

"Aggravation":
(a) the actual worsening of the worker's compensable condition(s) on a claim that has been closed by a Notice of Closure; or
(b) reclassification of a non-disabling claim as disabling at least one year after original acceptance.

Section 2: Reason for filing this form
(Complete on all reports. At least one reason must be checked.)
Check at least one reason for filing Form 1502. Associated dates must be reported in the spaces provided. The following are the most common reasons for filing Form 1502:

(F) First report of claim
File Form 1502 within 14 days of the insurer's initial decision to either accept or deny the claim. Form 1502 should be attached directly behind Form 801; and attach Form 827, if available, behind Form 1502. To report a disabling aggravation of a previously nondisabling claim, check reasons "F," "R," and "S."

(T) First report of new or omitted condition reopening
File Form 1502 within 14 days of reopening a claim made under ORS 656.267. Use Form 1503 (instead of Form 1502) to report new condition claims that can be closed within 14 days of the first to occur: acceptance of the new condition, or the insurer's knowledge that interim temporary disability compensation is due and payable. If the new or omitted condition claim is made after the worker's aggravation rights under ORS 656.273 have expired, file Form 3501 (instead of Form 1502); see OAR 438-012-0030(4) and OAR 436-060-0011(8).

(R) First report of claim for aggravation
File Form 1502 within 14 days of the insurer's decision to reopen or deny the claim under ORS 656.273. Report the date the insurer first received the claim for aggravation, i.e., the date of receipt of Form 827 signed by the worker or the worker's attorney and the worker's attending physician indicating an aggravation claim.

(V) First report of reopening for vocational training
File Form 1502 within 14 days of reopening the claim for vocational training services under OAR 436-120. Report the first date the worker is actively engaged in training.

(L) First report since a litigation order or stipulated agreement resulted in a change in the acceptance or disability status

File Form 1502 within 14 days of the date of a litigation order or stipulated agreement that changes the acceptance or disability status of the claim. Report the date the litigation order was signed by the approving authority or, in the case of a stipulation, the date an order approving the stipulation was signed by the approving authority.

(S) Change in acceptance or disability status
File Form 1502 within 14 days of the status change. Describe the change in the "Explanations" section. Attach a copy of the notice sent to the worker explaining the change.

(P) Notice of partial denial of accepted claim
File Form 1502 within 14 days of a denial that occurs after the initial Form 1502 has been filed on an otherwise accepted claim. Attach a copy of the denial letter.

(C) Correction of wage, SSN, date employer first knew of claim, TTD rate, etc.
File Form 1502 within 14 days of knowledge that previously reported data is incorrect. Describe the correction in the "Explanations" section.

(O) Other
Check the "Other" filing reason when the above filing reasons do not apply. Examples of appropriate use of this filing reason:
(1) to notify WCD that the claim was reopened in error, as reported on an earlier submitted Form 1502; or
(2) to report an amended denial. Describe the filing reason in the "Explanations" section.

(M) MCO enrollment after claim acceptance
File Form 1502 within 14 days of enrollment unless enrollment was previously reported by Form 1502. Complete Section 7.

Section 3: Weekly TTD rate based on paid through date
(Complete unless previously reported.)
Report the rate of temporary total disability (TTD) based on the "Paid through" date reported on Form 1502, unless there is no compensation due. Report the TTD rate even if the worker is receiving temporary partial disability. **Do not include supplemental disability in the TTD rate; report only the rate related to the employer-at-injury.**

Report the beginning "Paid from" date since the most recent opening or reopening of the claim and the last "Paid through" date at the time of filing Form 1502, unless there is no compensation due. Explain why "No compensation due" is checked (e.g., worker lost no time/wages from work).

Section 4: Weekly wage
*(Complete if a "First Report" box is marked in Section 2 or if reporting a wage correction, **unless** "No compensation due" is checked in Section 3.)*
Report:
(a) the weekly wage at the time of injury; or
(b) the weekly wage at the time there is medical verification that the worker is unable to work due to an occupational disease (ORS 656.210). If the weekly wage differs from the wage data included on Form 801, explain the wage computation in the "Explanations" section.

Section 5: Was first payment timely?
(Complete if a "First Report" box is marked in Section 2.)
Check "Yes" or "No" and provide the date of first payment *OR* check "Salary continued" (self-insured employer only – see ORS 656.262(4)(b) and OAR 436-060-0025) or "No compensation due," as applicable.

Section 6: Was claim accepted or denied timely?
(Complete upon acceptance or denial of original injury, new or omitted condition, or aggravation claim. Check "Yes" or "No" based on current status reported.)
Report if the claim was accepted or denied within 60 days after:
(a) employer's notice or knowledge of the claim, if a new claim;
(b) receipt of a claim for aggravation by the insurer in accordance with ORS 656.273; or
(c) receipt of a new or omitted condition claim under ORS 656.267.

Note: Only an order issued under OAR 436-060-0135 may extend the 60-day period.

Attach a copy of the notice of acceptance or denial letter sent to the worker to Form 1502.

Section 7: Enrolled in MCO?
(Complete unless enrollment was previously reported on a prior Form 1502 on the claim.)
If "Yes," provide date of enrollment and MCO number. Once enrollment is reported, completion of Section 7 on any subsequent Form 1502 is not required unless you enroll the worker in a different MCO.