WCD Claims Submission Tips

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Department of Consumer
and Business Services

Our agenda for today

- How to complete 1502 forms
- Avoid delinquencies
- Proper document submission
- Questions and answers

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

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

440-1502 (4/20/DCBS/WCD/WEB)

(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

Diving into the 1502 form

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

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 Mo. – Day – Yr.

Example of claim information

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.

ACME Insurance, Beta Claims Servicing, 100 High Street Salem, OR, 800-452-0288

Enter insurer information here.

INSURER'S REPORT

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

Worker's legal name: First **Robin**	MI **L**	Last **Smith**	WCD file no.:
Address: **350 Winter Street NE**			Date of injury (month-day-year):
City: **Salem**	State: **OR**	ZIP: **97301**	Social Security no.
Insured policy holder name as it appears on policy: **Department of Consumer and Business Services**			Insurer's claim no.:
Covered employer's legal name, if different from above: **Oregon Workers' Compensation Division**			Policy no.
Covered employer's address: **350 Winter St. NE**	City: **Salem**		Wrap-up project name, if applicable:
			State: **OR** ZIP: **97301**

Continuing the 1502 form

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

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 Mo. – Day – Yr.

WCD file no.:

Insurer and Box 1 information

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.

ACME Insurance, Beta Claims Servicing, 100 High Street Salem, OR, 800-452-0288

INSURER'S REPORT

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

	WCD file no.: **(Leave blank - WCD will fill in)**
Worker's legal name: First **Robin** MI **L** Last **Smith**	Date of injury (month-day-year): **4/17/2023**
Address: **350 Winter Street NE**	Social Security no. **123-45-6789**
City: **Salem** State: **OR** ZIP: **97301**	Insurer's claim no.: **2023-123456**
Insured policy holder name as it appears on policy: **Department of Consumer and Business Services**	Policy no. **85-96-123357**
Covered employer's legal name, if different from above: **Oregon Workers' Compensation Division**	Wrap-up project name, if applicable: **(special workers comp. coverage)**
Covered employer's address: **350 Winter St. NE** City: **Salem**	State: **OR** ZIP: **97301**

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 **Mo. – Day – Yr.**

Enter claim information here.

This may include a large construction project or similar work.

This will be specific to your claim, see claim paperwork for details. Be sure to complete **all boxes** to avoid an 873, delinquency, or sanctions.

Box 2 information

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.	☐ (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.)**

Box 2 example

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.	☒ (F) **First report** of claim **(Enter date employer first knew of claim - if not reported on attached 801.)** →	**4/18/2023**
		☒ **Check if** claim was previously accepted as nondisabling **(Attach acceptance letter; enter date of acceptance.)**	**5/01/2023**
		☐ (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.)**	

Box 3 information and example

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).**

Example:

3	**Weekly TTD rate** based on paid-through date.	$ 330.00	Paid from (this open period): 5/1/2023	Paid through: 5/14/2023	OR	☐ No compensation due. **(Skip to #6; explain below).**

Box 4 information and example

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.

Example:

4	**Weekly wage** *Complete on first reports and wage changes.*	**$ 500.00**	Explain weekly wage computation if based on information other than that shown on 801, or if 801 is not with first report.

WCD has online resources at https://wcd.oregon.gov/insurer/Pages/disability-calculators.aspx

Box 5 information and example

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.)

Example:

5	**Was first payment of compensation paid timely?** *Complete only on first reports.*	☒ Yes ☐ No	If payment was made, provide date of first payment. **5/15/2023**	**OR**	☐ Salary continued (self-insured employer). ☐ No compensation due. (Explain below.)

Box 6 information and example

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

Example:

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

Be sure to attach all notices of acceptance relevant to the claim. For this claim, attach both the initial notice of acceptance **and** the modified notice of acceptance (when the claim became disabling).

Box 7 information and example

7	**Is worker enrolled in an MCO?** *Complete unless enrollment was previously reported.*	☐ Yes ☐ No	If "Yes," provide date of enrollment.	MCO no.:

Example:

7	**Is worker enrolled in an MCO?** *Complete unless enrollment was previously reported.*	☒ Yes ☐ No	If "Yes," provide date of enrollment. **5/3/2023**	MCO no.: **900103**

If you mark "yes" you must include **both** the date of enrollment and the correct managed care organization (MCO) number. Failure to include both fields will result in an 873 letter and could result in sanctions if not responded to.

Completing the 1502 form

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.

440-1502 (4/20/DCBS/WCD/WEB)

1502

Completed 1502 example

Explanations: **New condition accepted, see attached modified notice of acceptance.**

FOR WCD USE ONLY

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

X *Terry Johnson*	**503-555-4752**	**5/15/23**
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.

440-1502 (4/20/DCBS/WCD/WEB)

1502

Every completed 1502 form needs:

- Status of the claim
- Weekly TTD rate and paid from and paid through dates or "no comp due"
- First payment timely
- Claim accepted or denied
- MCO information – both dates and valid MCO number

Completed 1502

All "first reports" need this information. If it is missing, it will result in an 873.

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

WCD file no.:

Worker's legal name: First: Robin	MI: L	Last: Smith	Date of injury (month-day-year): 4/17/2023
Address: 350 Winter Street NE			Social Security no.: 123-45-6789
City: Salem	State: OR	ZIP: 97301	Insurer's claim no.: 2023-123456
Insured policy holder name as it appears on policy: Dpartment of Consumer and Business Services			Policy no.: 85-96-123357
Covered employer's legal name, if different from above: Oregon Workers' Compensation Division			Wrap-up project name, if applicable:
Covered employer's address: 350 Winter St. SE	City: Salem	State: OR	ZIP: 97301

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

- [x] (A) Accepted
- [ ] (X) Denied
- [ ] (X) Partially denied
- [x] (D) Disabling
- [ ] (N) Nondisabling
- [ ] (Y) Fatality — Date of death:
- [ ] (Y) Occupational disease
- [x] (N) Injury
- [x] (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.
[x] (F) **First report** of claim (Enter date employer first knew of claim - if not reported on attached 801.)	4/18/2023
[x] **Check if** claim was previously accepted as nondisabling (Attach acceptance letter; enter date of acceptance.)	5/1/2023
[ ] (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.

$ 330.00 — Paid from (this open period): 5/1/2023 — Paid through: 5/14/2023 — OR — [ ] No compensation due. (Skip to #6; explain below).

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

$ 500.00 — 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.*

[x] Yes [ ] No — If payment was made, provide date of first payment. 5/15/2023 — 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.*

[x] 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.*

[x] Yes [ ] No — If "Yes," provide date of enrollment. 5/3/2023 — MCO no.: 900103

Explanations: New condition accepted, see modified notice of acceptance

FOR WCD USE ONLY

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

x *Terry Johnson* — Insurer's representative

503-555-4752 — Phone no. of representative

5/15/23 — Date mailed

Help with the 1502 form

If you have questions as you complete the 1502, look at the back of the form.

You will find instructions there to help you accurately complete the form and avoid 873 letters and sanctions.

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.

I’m here to help!

Olivia Brookman, Claim Records research specialist

971-283-4964

Olivia.L.Brookman@dcbs.Oregon.gov

Questions

801 Processing and Completing for Insurers

Keith Johnson, claims coding trainer

Department of Consumer
and Business Services

What is an 801 form?

A required document submitted to WCD at time of an injury or incident.

Contains information about the injury and the injured worker.

Form data is used in state and federal databases.

What is the purpose of the 801 form?

- The initial injury report for an Oregon workers' compensation claim.
- Serves as a release of medical records for claims administration.
- Notifies the insurance company of the illness or injury.
- Describes the five W's of the claim: who, what, when, where, and why.

Diving into the 801 form

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off: M T W T F S S	DEPT USE: Emp
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part
				Ev
				Sre
				2sre

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:			
Home phone:	Work phone:	Occupation:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised:	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		
Were other workers injured? ☐ Yes ☐ No		OSHA 300 log case no:

Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

Employer signature:	Name and title (please print):	Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

440-801 (1/21/DCBS/WCD/WEB)

801

Beginning with the top of the form

This is the injury description. It should contain:

- Date of injury
- Date left work
- Time left work
- Time work began
- Time of injury/illness
- Type of injury (if known)
- Description of incident
- Regularly scheduled days off

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness
Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:**
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part
				Ev
				Src
				2src

Writing the injury and description

Jenn fell down the stairs on her way into the work building. She was carrying a venti, extra hot, white chocolate mocha in her left hand and her heavy work bag in her right hand. Before falling down the stairs, Jenn was worried about getting to her desk on time, because her shift starts at 8 a.m., exactly.

Jenn was wearing 3-inch, high-heeled shoes and a floor-length maxiskirt at the time of the injury. She had a history of being late to work in the past few months, so Jenn was in a hurry. I think if Jenn had been on time and not wearing such high heels, this injury wouldn’t have happened.

How would you better summarize this for the 801?

A proper description of the incident

The large box on the top of the form is for how the worker was injured.

A summary of the incident that caused the injury is needed.

A proper description of the incident

Example: “Was mopping floor and didn’t know a puddle of soapy water was there and I slipped and fell hurting my ankle and back.”

Insert self-insured employer and insurer name, address, phone number, and service company, if any.
Razadazzle Insurance Company
PO BOX 333
888-121-0077

Report of Job Injury or Illness
Workers’ compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers’ compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness: 3/4/2023	Date you left work: 3/4/2023	Time you began work on day of injury: 9 ☒ a.m. ☐ p.m.	Regularly scheduled days off: ☒☐☐☐☐☐☒ M T W T F S S	DEPT USE:
Time of injury or illness: 1:30 ☐ a.m. ☒ p.m.	Time you left work: 2:30 ☐ a.m. ☒ p.m.	Check here if you have more than one job: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☒ Left ☐ Right Twisted ankle, pain in lower left back				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials) Was mopping floor and didn't know a puddle of soapy water was there and I slipped and fell hurting my ankle and back				Part
				Ev
				Src
				2src

Middle of the form

In the middle is the claimant information. This should be filled out as fully as possible.

- Name
- Address
- Date of birth (DOB)
- Gender
- Occupation
- Hospitalization/ER
- Health care provider
- Signature
- Phone number (work and home)

Example of the claimant information

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name: **Whitley Callan Dixon**	Language preference: **English**	Birthdate: **9/21/1999**	Gender: M ☒ F ☐
Your mailing address: **147 SE Beaver Ave, Oregon City, 97045**			
Home phone: **503-555-9009**	Work phone: **252-762-9951**	Occupation: **Janitorial Service Rep.**	
Names of witnesses: **Matt and customer in office**			

Name and phone number of health insurance company: **Providence 800-660-2222**	Name and address of health care provider who treated you for the injury or illness you are now reporting: **Providence ER, West Linn, Dr. Hart**
Were you hospitalized overnight? ☐ Yes ☒ No	
Were you treated in the emergency room? ☒ Yes ☐ No	

By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.

Worker signature: *Whitley Dixon*	Completed by (please print): **Whit Dixon**	Date: **3/7/2023**

Digital signatures on the form <u>are</u> accepted.

Ending with the bottom of the form

- Legal business name
- Client's name
- Principal place of business (headquarters)
- Where staff members are supervised from
- Where the injury or illness occurred
- Employer knowledge date (when the employer was aware of the injury)
- Date worker returned to work

Ending with the bottom of the form

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised:	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:		

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

Were other workers injured? ☐ Yes ☐ No			OSHA 300 log case no:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I **understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

Employer signature:	Name and title (please print):	Date:

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440-801 (1/21/DCBS/WCD/WEB)

801

Questions?

Keith Johnson
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971-345-1547