

Insurer Notice of Closure Summary

			WCD File No.
Worker (legal name) First	MI	Last	Date of injury (Mo.-Day-Yr.)
Address			SSN
City	State	ZIP	Insurer's claim #
Employer (legal name), address, city, state, ZIP			Date claim statutorily qualifies for closure
Attending physician		Worker's attorney	

Notice to worker: This copy is **for your information only**. No action is required if the information is correct. Immediately report any incorrect information to your insurer and to the Oregon Workers' Compensation Division, (503) 947-7585, (800) 452-0288, or TTY only: (503) 947-7993.

1. Reason for filing this form *(Attach the Notice of Closure, Worksheet, and Updated Notice of Acceptance at Closure as applicable.)*

- (A) Notice of Closure
 - Yes
 - No
 Is the claim being closed after reopening for an accepted **new condition**? See ORS 656.262(7)(c).
- (J) Correct Notice of Closure dated _____ **Provide the mailing date printed on the (prior) Notice of Closure being corrected or rescinded.**
- (U) Rescind Notice of Closure dated _____
- (W) Request for Preferred Worker eligibility review pursuant to OAR 436-110-0240

2. Claim information since date of injury

Time-loss: Total _____ weeks and/or _____ workdays of **TTD** paid since DOI. Total \$ _____ **TTD** paid since DOI.
 Total _____ weeks and/or _____ workdays of **TPD** paid since DOI. Total \$ _____ **TPD** paid since DOI.
 Check here if you are aware of an overpayment of time-loss benefits.

Medical \$ _____ Total medical costs paid (including charges received but not yet paid at time of this filing)

3. Preferred Worker and vocational information (At the time of claim closure)

Accurate information is necessary to determine the worker's eligibility for Preferred Worker and vocational benefits.

<p>Return to work type (Check one.)</p> <input type="checkbox"/> (J) Job at injury (same employer) <input type="checkbox"/> (A) Job at aggravation (same employer) <input type="checkbox"/> (M) Modified/restricted duty <input type="checkbox"/> (N) New job <input type="checkbox"/> (X) No job <input type="checkbox"/> (D) Worker is deceased (Do not complete the remainder of Section 3.)	<p>Release to work type (Check one.)</p> <input type="checkbox"/> (J) Job at injury without restrictions <input type="checkbox"/> (A) Job at aggravation without restrictions <input type="checkbox"/> (M) Restricted duty due to compensable conditions <input type="checkbox"/> (Z) Work restrictions NOT due to compensable conditions <input type="checkbox"/> (X) Unable to work at all due to compensable conditions (PTD) <input type="checkbox"/> (Y) No closing medical information received (administrative closure under OAR 436-030-0034)
<p>Employer type (Check one.)</p> <input type="checkbox"/> (S) Employer at injury <input type="checkbox"/> (A) Employer at aggravation <input type="checkbox"/> (N) New employer <input type="checkbox"/> (X) Not employed	<p>Employment status (Check one.)</p> <input type="checkbox"/> (P) Permanent <input type="checkbox"/> (T) Temporary <input type="checkbox"/> (X) Not employed

Yes **Did the worker refuse appropriate employment with the employer at original injury or employer at aggravation?**
 No *Appropriate employment is defined in OAR 436-110.*

<p>Explanation:</p> <p><i>I certify this information is true and correct, and that all dates required are entered and accurate:</i></p>	<p>DCBS USE ONLY</p>

Form 1503 completion instructions

(not all data fields are described):

<u>Section/ number</u>	<u>Description/explanation</u>
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Heading: “Date claim statutorily qualifies for closure”

This is the date the claim satisfies the provisions of ORS 656.268(1).

1.A. “Is the claim being closed after reopening for an accepted new condition?” Yes/No

Check yes if the claim was opened pursuant to ORS 656.262(7)(c); See OAR 436-060-0010(15) and (16).

1.W. “Request for Preferred Worker eligibility review pursuant to OAR 436-110-0240”

Use this filing option if the conditions of OAR 436-110-0240 (5) (b) + (c) have been met.

2. “Time-loss”

Report TTD and TPD dollars and days actually paid since the date of injury, regardless of prior closures. Do not include any supplemental disability dollars or days paid (pertinent to additional jobs the worker held at the time of injury). Each day or part of a day for which any TTD or TPD is paid counts as one day. Self-insured employers that continue wages in lieu of paying time-loss must report the time-loss that otherwise would have been paid. Report time-loss as a combination of weeks and days, or as days only, or as weeks only.

Example: Report **either** as 4 weeks and 2 days, or as 22 days – **not both**.

“Check here if you are aware of an overpayment of time-loss benefits.”

Your checkmark will explain some discrepancies between time-loss paid and authorized and may reduce the number of Form 873 information requests.

3. “Preferred Worker and vocational information”

“Job at injury” and “Job at aggravation” refer to the worker’s job at the time of the injury or aggravation **with the same employer**. If the worker returns to the same type of work but with a new employer, check “New job” or “Modified/restricted duty” (whichever is applicable) under “Return to work type.” If the worker held a 2nd job at the time of injury and returns to work at the 2nd job, the “Return to work type” is “(N) New job” and “Employment type” is “(N) New employer.”

The terms “Job at injury,” “Modified/restricted duty,” and “Restricted duty” refer only to the employer-at-injury (where the worker was injured) and NOT to a 2nd or additional employer of the worker at the time of injury.