DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

Reopened Claims Program
Reimbursement Request

Quarter: _____ Year: _____

☐ **Self-Insured Employer** ☐ **Insurance Company**

To: Department of Consumer & Business Services
Workers' Compensation Division, Compliance Section
In-Office Audit & Certifications Unit
350 Winter St. NE, PO Box 14480, Salem, OR 97309-0405

I certify that the payments reported have been made in the amounts indicated, pursuant to ORS 656.278 and ORS 656.625, and have not been previously requested.

Reimbursement is requested in the amount of: $ **0.00**

Signed: **X** _____ Date: _____

Type name, title, and phone: _____ **( ) -** _____

Mail reimbursement to:

Insurance company or self-insured employer **(and TPA if applicable)** name and address: _____

_____

_____

_____

City State ZIP

1. File number and claim number	2. Workers' names (alpha order) last, first	3. DOI or date of 1st disability if occ. disease (If occ. disease, note O/D.)	4. Weekly wage	5. Days off	6. Marital/ dependency status	7. Temporary disability period	8. TTD/TPD dollar amount	9. Permanent disability dollar amount	10. Total payments
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**
WCD Ins.						From Through			**$0.00**