

Insurer Notice of Closure Summary

			WCD file no.
Worker (legal name) First	MI	Last	Date of injury (Month-Day-Year)
Address			Insurer claim no.
City	State	ZIP	Was the claim closed timely? ☐ Yes ☐ No
Employer (legal name), address, city, state, ZIP			
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 Workers' Compensation Division, 503-947-7585 or 800-452-0288.

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 Is the claim being closed after reopening for an accepted **new medical condition**?
☐ No See ORS 656.262(7)(c).

☐ (J) Correct Notice of Closure dated _____

Note: Provide the mailing date printed on the (prior) Notice of Closure being corrected or rescinded.

☐ (U) Rescind Notice of Closure dated _____

2. Claim information since date of injury

Time Total _____ weeks and/or _____ workdays of **TTD** paid since DOI. Total \$_____ **TTD** paid since DOI.

loss: 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 (on the date the claim is closed)

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

Return to work type (Check one.)

- ☐ (J) Job at injury (same employer)
☐ (A) Job at aggravation (same employer)
☐ (M) Modified/restricted duty
☐ (N) New job
☐ (X) No job
☐ (D) Worker is deceased (Do not complete the remainder of Section 3.)

Release to work type (Check one.)

- ☐ (J) Job at injury without restrictions
☐ (A) Job at aggravation without restrictions
☐ (M) Restricted duty due to compensable conditions
☐ (Z) Work restrictions NOT due to compensable conditions
☐ (X) Unable to work at all due to compensable conditions (PTD)
☐ (Y) No closing medical information received (administrative closure under OAR 436-030-0034)

Employer type (Check one.)

- ☐ (S) Employer at injury
☐ (A) Employer at aggravation
☐ (N) New employer
☐ (X) Not employed

Employment status (Check one.)

- ☐ (P) Permanent
☐ (T) Temporary
☐ (X) Not employed

☐ Yes ☐ No **Did the worker refuse appropriate employment with the employer at original injury or employer at aggravation?**

Explanation:

DCBS USE ONLY

I certify this information is true and correct, and that all dates required are entered and accurate:

Insurer representative signature

Date

Name and title (please print)

Phone/extension

440-1503 (5/24/DCBS/WCD/WEB)

1503

Form 1503 completion instructions

(not all data fields are described):

**Section/
number**

Description/explanation

“Was the claim closed timely?”

Check “yes” or “no” based on whether the claim was closed within the time requirements outlined in OAR 436-030.

1.A.

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

Check “yes” if you opened the claim under ORS 656.262(7)(c). See OAR 436-060-0011.

2.

“Time loss” or “Temporary total disability (TTD) and temporary partial disability (TPD)”

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 (resulting from 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 paying wages instead of paying temporary disability must report the benefits that would have been paid if they had not paid wages. Report temporary disability as a combination of weeks and days, as days only, or as weeks only.

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

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

Checking this box may explain some differences between time-loss paid and time-loss authorized. This 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 second job at the time of injury and returns only to work at the second 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). These terms do not refer to a worker’s second or additional employer at the time of injury.