Workers' Compensation Division
Department of Consumer and Business Services

Reopened Claims Program Reimbursement Request

Quarter: ____________ Year: ___________

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

To: Department of Consumer & Business Services
Workers' Compensation Division, Performance Section
Audit and Reimbursements Team
350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405

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

Reimbursement is requested in the amount of: $ ________________

Signed: ______________________________ Date: ______________

Type name, title, and phone: ______________________________

Mail reimbursement to:

Insurance company or self-insured employer **(and service company, if applicable)** name and address: ______________________________

City State ZIP

1. File number and claim number	2. Workers' names (alphabetical 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. Disability type*	8. Dollar amount	9. TPD/TTD/PTD period	10. Total payments
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	
WCD Ins.						☐ TPD/TTD ☐ PTD ☐ PPD		From Through	

*Temporary Partial Disability (TPD); Temporary Total Disability (TTD); Permanent Total Disability (PTD); Permanent Partial Disability (PPD)