Workers' Compensation Division
Department of Consumer and Business Services

Preferred Worker Program
Quarterly Claim Cost Reimbursement Request

_____ Quarter _____ Year

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

To: Department of Consumer and Business Services
Workers' Compensation Division, Performance Section
Self-Insurance, Registration, and Reimbursements Team
350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
Fax: 503-947-7725

Submit a request for reimbursement to the division within 15 months of the date on which payment was made. (OAR 436-110-0330(2)(a))

I certify that:

1) The costs listed are reimbursable claim costs under Oregon Administrative Rule 436-110-0330. (Note: The Workers' Compensation Division will determine the appropriate administrative cost factor, as published in Bulletin 316, and apply it to the reimbursement.)
2) The claim costs reimbursed by the Preferred Worker Program may not be included in the data that will affect employer rates or dividend eligibility.
3) The payments reported have been made in the amounts indicated and have not been previously requested. Reimbursement is requested in the amount of ____.

All costs must indicate the quarter and year of actual payment.

Signed: _____ Date: _____

Name and title: _____ (Print or type)

Phone: _____ (Print or type)

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

_____

_____

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_____

City State ZIP

Preferred worker number*	Claim status: Nondis. or Disabling N	Claim status: Nondis. or Disabling D	Insurer claim number	Claimant name(s) (Alphabetical order: last, first)	Date of new injury	Date of hire for this job**	Quarter/ year of payment	Claim costs: Disability type*** TTD	Claim costs: Disability type*** PPD	Claim costs: Disability benefits	Claim costs: Medical benefits	Claim costs: Total costs
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							Totals from Page 1:					
							Totals from all additional pages:					
							Totals:					

***Preferred worker number is the same as the WCD file number of the qualifying claim.**
****Required on first request.**
*****Temporary Total Disability (TTD); Permanent Partial Disability (PPD)**