Section 7
Forms

Overview of Forms

Most of the forms that the department has created are required by statute and rule and are necessary to all of the users of the workers' compensation system. They are kept as up-to-date and user friendly as possible.

All parties must use the required forms to report information, including payments made on claims. The department uses the information to verify the accuracy and timeliness of payments, and for statistical purposes.

Besides the obvious data (compensation rate, periods of benefits paid, etc.), the forms include instructions to the employee that are **extremely** important. For instance, the forms tell employees about their time limits for requesting a discontinuance conference or the statute of limitations on contesting a denial of primary liability.

The timely filing of these forms is important for several reasons:

- Filing of the First Report of Injury (FROI) usually starts the statute of limitations.
- Employees are informed of their rights and benefits quickly.
- Parties will avoid getting requests from the department for additional claim information.
- Parties can avoid penalties for late filing of the forms.

Note: If a claim does not involve any claimed disability beyond the waiting period and doesn't include possible PPD, the statute does NOT require that a FROI be filed with the department unless another required form is being filed. Requirements for filing subsequent documents apply to this type of claim ONLY if the FROI has already been (perhaps mistakenly) sent to the department.

All workers' compensation forms, including required and optional, can be found on our website at www.dli.mn.gov/WC/Wcforms.asp.

The following pages are meant to be a guide on how to properly fill out and file the most common forms.

First Report of Injury (FROI)

Time Requirements

The FROI is the reporting document for all injuries that are claimed to be work-related. It provides basic information necessary to start the claim. A FROI must be

filed electronically with the department on all injuries where the claimed disability exceeds three calendar days. In addition, for any injury where the claimed disability does not exceed three calendar days, a FROI must be sent to the department at the time any other required form is filed, e.g. when making payment of PPD.

Deaths and serious injuries must be reported to the department within 48 hours. This can be done via telephone, facsimile, or electronic transmission, to be followed by the FROI within 7 days.

For all other injuries, where claimed disability exceeds three calendar days, the following time frames for reporting the injury apply:

- For self-insured employers, the FROI must be filed with the department within 14 days of the later of the first day of any claimed disability or the date the employer was aware of the claimed injury and disability.

- Where the employer is not self-insured, the employer has 10 calendar days from the later of the first day of any claimed disability or the date the employer was aware of the claimed injury and disability to get the FROI to their insurance company. The insurer has 14 calendar days from the later of the first day of any claimed disability or the date the employer was aware of the claimed injury and disability to file the FROI to the department.

The employee must be given a copy of the FROI along with the employee information sheet.

Employees are not responsible for completing the FROI. The form should be filled out completely, accurately, legibly, and timely by the employer. The information provided on the FROI is used by the department to set up the claim and when assessing penalties. More information regarding penalties for the late filing of the FROI can be found in the Section 5.

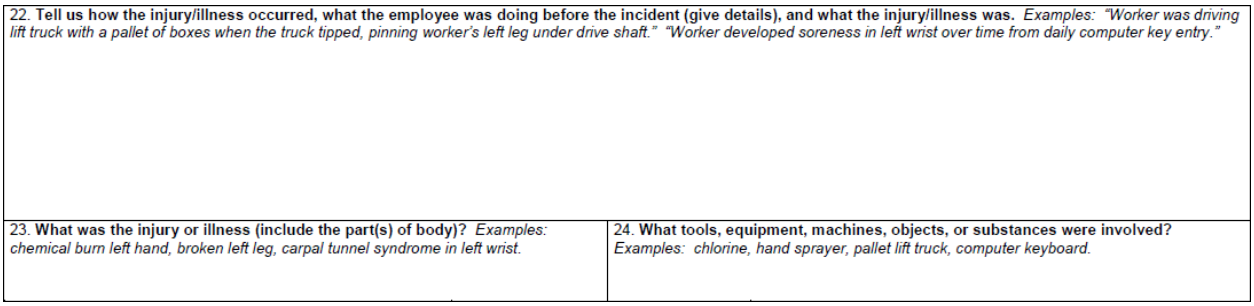
How to Complete the Form

Make sure the information on the FROI is as accurate as possible before the FROI is filed with the department.

Note: There are specific instructions on the back of the FROI for how and when to complete the form. Below are notes concerning the information needed in some of the important boxes from the FROI.

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City State Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

Box #	
1	The SSN is used to initially identify the claim. (On future forms the WID can be used to replace the SSN.) The FROI can be rejected if SSN is not properly filled out.
4	The DOI is used to identify the claim, especially for claimant with more than one claimed injury. The FROI can be rejected if the DOI is not properly filled out.
7	The employee name is used to identify the claim. The FROI can be rejected if the employee name is not properly filled out.

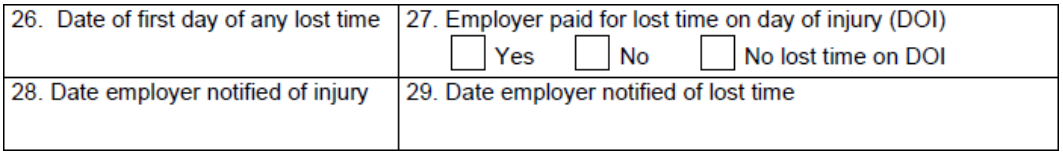


22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*

24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

Box #	
22	This should be used to describe what the employee is claiming happened i.e. what the claimed injury is and how it occurred. Be specific.
23	This should be used to specify what the injury or illness is, including the part(s) of the body injured.
24	This should be used to specify what equipment etc., if any, was being at the time of the injury.



26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
28. Date employer notified of injury	29. Date employer notified of lost time

Box #	
26	This is the first day of any claimed lost time, including lost time where the employee stops working to receive medical treatment. This includes on-site medical treatment.
27	This is used to explain whether the employee was paid for the lost time on the date of injury, if any.
28	This is the date when was the employer first became aware of the claimed injury.
29	This is the date when was the employer first became aware that the lost time was claimed to be related to the claimed injury.

36. **EMPLOYER** Legal name			37. EMPLOYER DBA name (if different)	
38. **Mailing** address			39. Employer FEIN	40. Unemployment ID #
City	State	Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet	
City	State	Zip Code	44. NAICS code	45. Date form completed

Box #	
36-42	These boxes are used for the employer's company names (legal and DBA), addresses (mailing and physical), and contact person (name and phone #).
45	This is the date the form was completed by the employer.

46. **INSURER** name		51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN		52. CA address	
48. Policy # (including effective dates) or self-insured certificate #		City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. CA claim #

Box #	
46	This is used for the name of the insurer (insurance company or self-insured employer).
50	This is the date the insurer first receive notice of the claimed injury.
51/52	These boxes are used for the name and address of the company that is administering the claim. Either the insurer or third-party administrator.

Notice of Insurer's Primary Liability Determination (NOPLD)

Time Requirements

For injuries with claimed disability extending more than three calendar days, the insurer must make a determination regarding liability within 14 days of the first day of disability or the date the employer was aware of disability, whichever is later. This means insurer must pay or deny a claim within 14 days. Failure to pay or deny within 14 days can result in penalties. More information regarding penalties for late payments and late denials are discussed in the Section 5.

The NOPLD form is used to notify the employee (or heirs/dependents of an employee), the employer, and the department of the insurer's position regarding primary liability on the claim, including specific details of the accepted or denied claim. It is important to remember that this form could be completed several different times on the same claim to reflect changes in the insurer's position or changes in the specific details of the claim. These subsequent filings of the form would be

considered amended NOPLD forms. In addition, this form outlines the employee's rights and responsibilities.

The department uses the information supplied on the form to review for timely and accurate compliance with the statutes and rules, for statistical data, and to publish a legislatively mandated annual report about the promptness of insurers' first actions on claims.

Reasons to File

The NOPLD must be filed at least once whenever a FROI indicating there was claimed disability extending more than three calendar days has been filed - NO EXCEPTIONS. It is used to report:

- the first payment of wage loss benefits;
- acceptance of liability, but denial of initial wage loss benefits;
- a denial of primary liability.

The NOPLD can be required more than once for some claims. For instance:

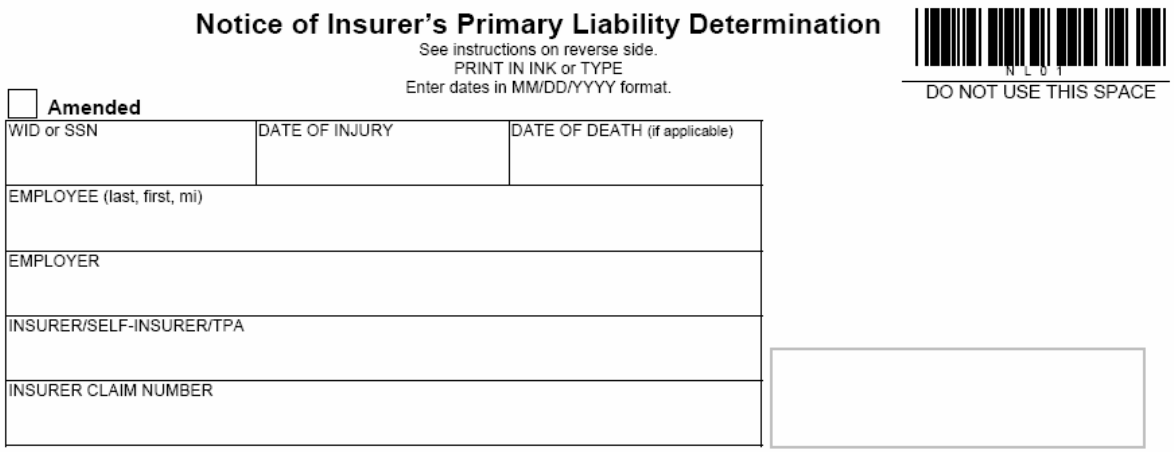
- When the insurer initially denies primary liability, but later accepts liability.
- When the insurer initially accepts a claim and pays wage loss benefits, but later denies primary liability within 90 days pursuant to Minnesota Statutes §176.221, Subd. 1.
- When the insurer accepts a claim on which there are no wage loss benefits initially paid, but later pays wage loss benefits voluntarily.

Note: This form is not to be used to report a resumption of wage loss payments after they have been previously discontinued. The Notice of Benefit Reinstatement form is used for this purpose.

When to File

- When making payment, the form should be filed at the time the initial payment is made.
- When denying primary liability or denying partial liability (for the initial claimed disability), the form must be filed within 14 calendar days from the later of the first day of any disability or the date the employer was aware of the claimed injury and disability.

How to Complete the Form



Notice of Insurer's Primary Liability Determination

See instructions on reverse side.
PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

☐ **Amended**

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE (last, first, mi)		
EMPLOYER		
INSURER/SELF-INSURER/TPA		
INSURER CLAIM NUMBER		

The boxes in the upper left hand corner on the front of the form containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, Insurer, and Claim Number) must be fully completed each time the form is filed. Also, since the NOPLD can be filed more than once, an Amended Box is placed at the top of the form. Be sure to check this box for any subsequent filings of the NOPLD.

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER (area code)	EXTENSION	DATE SERVED (must be completed)

Likewise the boxes at the bottom of the form, the claim representative's name and phone number, and the date the form is being served on the parties, must be fully completed each time the form is filed. No signature is required, but it is important to note that the name and phone number, including extension, must be for the person who actually made the primary liability determination, not for the person who is filling out the form (if different).

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
If the initial return to work was followed by a new period of lost time, complete the following information: First date of new period of lost time: _____		Date employer notified of this lost time: _____	

The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must be completed, if applicable, each time the form is filed, regardless of the liability determination. Also, if the employee initially returns to work before the insurer sends this form to the department, (e.g. the initial claimed disability was within the waiting period) and there is a subsequent period of disability, they must fill in the first date of the period of subsequent disability and the date the employer was notified of this new period. Remember that:

- The first date of lost time is the first day of any claimed lost time including partial days. It does not have to be a full day of claimed lost time.

- The date the employer was notified of the lost time is the date the employer became aware that the lost time was claimed to be related to the injury.

- In circumstances where the employee initially returned to work but starting losing time again before the NOPLD is filed, report the first date of the new period of lost time as well as the date the employer was aware of the lost time.

Boxes 1, 2, and 3 are used to explain why the form is being filed. **Only one box should be checked**.

☐ **1. Your claim is ACCEPTED and wage loss benefits will be paid.**

Benefit type: ☐ Temporary Total (TTD) ☐ Temporary Partial (TPD) ☐ Permanent Total (PTD) ☐ Dependency (DEP)			
Date of payment	Amount of payment	Time period covered with this payment Date from — Date through	Compensation rate
Any ongoing payments will be made on _____ (day of week) at_____(weekly, biweekly, etc.) intervals.			
Check all that apply	☐ Full wage continuation by the employer under M.S. § 176.221, subd. 9. ☐ TPD payment made according to the wage loss verification received by the insurer on _____(date). ☐ Fatality with dependents. Payment is being made according to dependent information, which must be **ATTACHED**. ☐ Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.		

Box 1 should be checked to report acceptance of liability for the claim and payment wage loss benefits. Complete all fields in this section.

- Check the box that explains what type of benefit will be paid. If more than one type of benefit is being paid on that first check, check the box for the type of ongoing benefit this will to continue to be paid.

- Provide the date and amount of the first payment. These boxes are only to be filled in when the insurer is issuing a check. Do not enter a date and amount of payment when the employer is paying full wage continuation and no check is being issued by the insurer.

- Provide the time period covered with the payment and the compensation rate. Make sure to fill in these boxes even if the employer is paying full wage continuation and the insurer isn't issuing a check.

- Provide the date and frequency of ongoing payments, if any.

Check any of the additional boxes in the bottom part of this section as needed. **Only one box may be checked**. For instance:

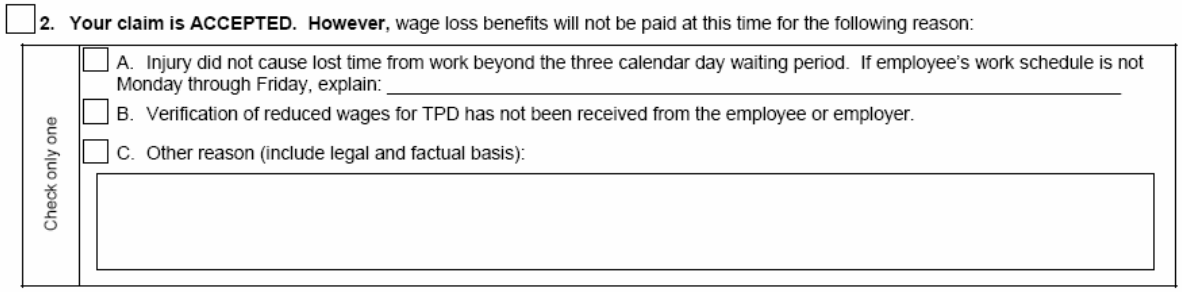
- Where the employer is paying full wage continuation, check the appropriate box.

  Note: The insurer still must file any additional forms at the appropriate times and showing the benefits paid as required by Minnesota Statutes §176.221, Subd. 9.

- Where payment is for TPD benefits, check the appropriate box and explain when the wage loss verification was received by the insurer.

- Where payment is for a fatality with dependents, check the appropriate box and be sure to attach the dependent information.

- Where payment is for a fatality with no dependents, check the appropriate box to show that payment is being made to the estate or Special Compensation Fund.



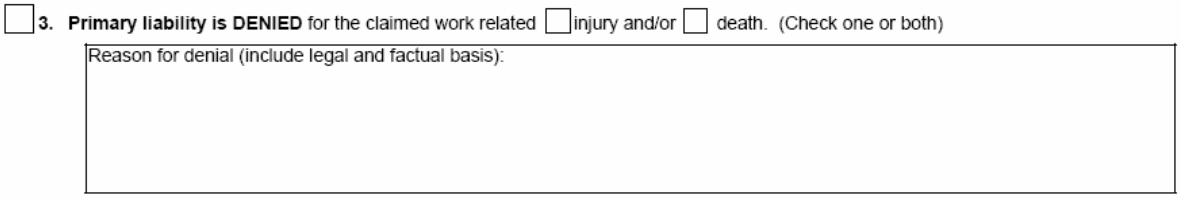
Box 2 should be checked to report the acceptance of liability for the claim, but where payment of wage loss benefits is being denied (a partial denial). Check one any of the boxes (A, B, or C) in this section to explain why the wage loss benefits are being denied. **Only one box may be checked**. For instance:

- Box A is used where the employee did not have any claimed lost time beyond the waiting period. To help clarify possible questions, provide the employee's work schedule if it is not Monday through Friday.

- Box B is used where the claim is for TPD only, but the insurer is unable to make payment because there is not sufficient wage loss verification to determine the any amount due. An amended NOPLD must be filed once the initial payment is made (Box 1) or when the insurer determined there was no disability beyond the waiting period (Box 2 A).

- Box C is used where the insurer is denying payment for the claimed disability beyond the waiting period for any other reason. The reason for the denial must be stated clearly in the space provided. The reason needs to include a legal, factual, and specific reason easily understood by someone of average intelligence. (See Minnesota Statutes §176.84, Subd. 1 for more information.) Medical reports or other documentation used to support the denial must be attached.

  Note: If the box provided does not give enough room for a full explanation, write "see attached" and attach a separate page.



Box 3 should be checked to report a denial of primary liability for the claim. The

insurer must:

- State a clear reason for the denial in the space provided. The reason needs to include a legal, factual, and specific reason easily understood by someone of average intelligence. See Minnesota Statutes §176.84, Subd. 1 for more information.

Note: If the box provided does not give enough room for a full explanation, write "see attached" and attach a separate page.

- Attach medical reports or other documentation used to support the denial.

Note: Avoid simple mistakes when denying liability. For example:

- Statements such as "We have no medical reports to support the injury or disability." or "The injury did not arise out of and in the course and scope of employment." when given as the sole basis for a denial are deemed non-specific per Minnesota Rules Part 5220.2570, Subp. 2.

- Denying liability without conducting or attempting a good faith effort to conduct an investigation is prohibited per Minnesota Statutes § 176.194, Subd. 3(4). Statements such as "Our investigation is continuing." or "We will re-evaluate liability once our investigation is complete." without documenting that an investigation was completed or attempted in good faith should not be used.

For additional information regarding liability determinations see Minnesota Statutes §176.194, Subd. 3(4) and Subd. 4, 176.221, Subd. 3a, and 176.225, Subd. 1. Also see Minnesota Rules Parts 5220.2570, Subp. 10B, 5220.2540, Subp. 4, 5220.2760, Subp. 1C, and 5220.2770, Subp. 2E.

Notice of Intention to Discontinue Workers' Compensation Benefits (NOID)

The purpose of the NOID form is to notify the employee of a reduction or discontinuance of wage loss benefits, the amount of benefits paid on the claim, and their right to an administrative conference. It must be served on parties as noted on the form.

The department uses the form to review for compliance with the statute and rules, to verify calculation of benefits, and for statistical data.

Note: *Always attach an "Employee's Request for Administrative Conference" form to the employee's copy of the form.*

Reasons to File

To discontinue or reduce TTD, TPD, or PTD:

1) when the employee returns to work at full wage;

2) when the employee returns to work at reduced wage; or

3) for reasons other than a return to work.

When to File

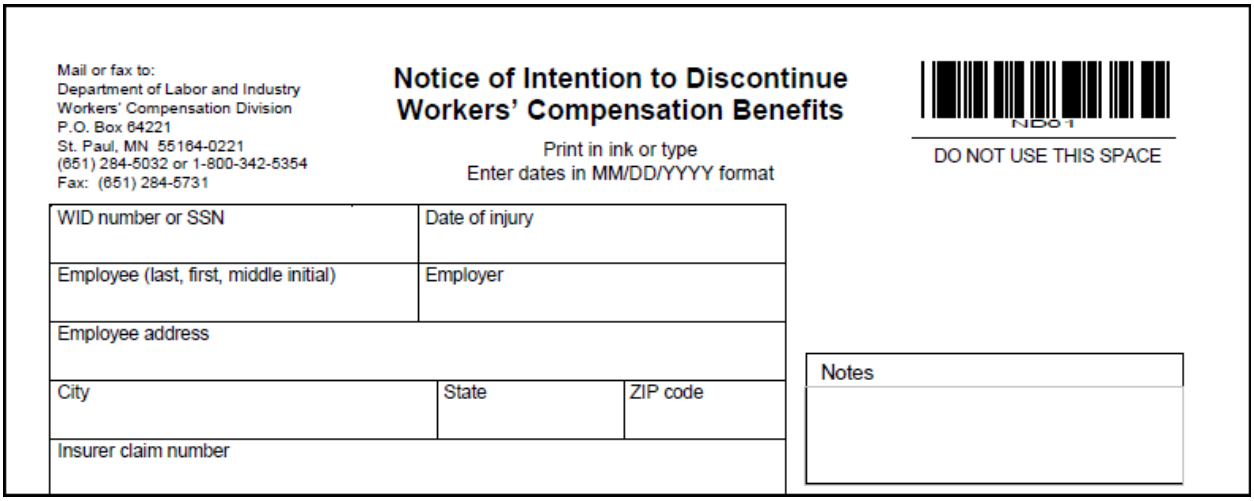
- Within 14 days of the date the insurer receives notice that the employee has returned to work (# 1 or 2 above).

- At the time of discontinuance for reasons other than return to work (#3 above). This includes situations where the insurer is discontinuing benefits when they are denying primary liability and it is more than 90 days from the first day of disability or the date the employer was aware of disability, whichever is later.

Note: Pay benefits through the date of service of the NOID when discontinuing for reasons other than return to work (there are rare exceptions to this requirement). Making sure the NOID form is served promptly is advantageous to the insurer.

How to Complete the Form

Front Page



Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Intention to Discontinue Workers' Compensation Benefits

Print in ink or type
Enter dates in MM/DD/YYYY format

ND01
DO NOT USE THIS SPACE

WID number or SSN	Date of injury	
Employee (last, first, middle initial)	Employer	
Employee address		
City	State	ZIP code
Insurer claim number		

Notes

The boxes in the upper left hand corner containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, Insurer, and Claim Number) must be fully completed each time the form is filed.

Your benefits for (check one) ☐ temporary total disability ☐ temporary partial disability ☐ permanent total disability are being discontinued or reduced for the following reason(s):

☐ 1. You returned to work at full wage on _____ (date).

☐ 2. You returned to work at reduced hours or wage on _____ (date).

Temporary partial disability benefits ☐ will be paid or ☐ will not be paid. Temporary partial disability benefits are usually two-thirds of the difference between your average weekly wage at the time of the injury and your current weekly wage.

☐ 3. For reasons other than return to work as stated below. (Relevant medical reports or other documents must be attached.) Payment will be made through _____ (date).

Reasonable medical expenses and any permanent partial disability due will still be paid unless your claim has been denied.

Check one box for **type** of benefit being discontinued (TTD, TPD, or PTD).

Check one box for **reason** for discontinuance.

Box 1 is used where the employee has returned to work at full wage. Give the return to work date in the space provided.

Note: The return to work date is the date the employee actually returned to work. It is not the date the employee is expected to return to work nor the date which the employee was released to return to work.

Box 2 is used where the employee has returned to work at reduced wage. Give the return to work date in the space provided. Indicate whether TPD will or will not be paid by checking the appropriate box and list the Average Weekly Wage on the date of injury.

Note: If TPD benefits will not be paid, explain why in the space provided below Box 3.

Box 3 is used for any reason to discontinue other than the actual return to work of the employee. The insurer must:

- Explain in the space provided, the specific legal and factual reason for discontinuing benefits. This explanation needs to be in language easily understood by a person of average intelligence. See Minnesota Statutes §176.84, Subd. 1 for more information.

  Note: If the box provided does not give enough room for a full explanation, write "see attached" and attach a separate page.

- Attach any medical reports or other documents used in support of the reason for discontinuance.

Note: It is important to list any and all reasons for the discontinuance of benefits and attach all supporting documentation.

Back Page

You are required to completely and accurately fill out the back side of the NOID each time you file the form.

	Average weekly wage at DOI $_____	Include contingent attorney fees in benefit totals					
	The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**	
	☐ Temporary total disability or ☐ Permanent total disability Notes ☐ Benefit addendum attached						

TTD and PTD:

- Check the appropriate box or boxes.
- Report each period of benefits paid on a separate line. Do not lump them together all on one line. A break in continuous dates of TTD or PTD or a change in the weekly payment rate constitutes a start of a separate period of benefits paid.
- On each line list the from date, through date, number of weeks paid, compensation rate, and total benefits paid for that period.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.
- Any important notes can be written in the box provided. (For example: "Employee works a 3-day week" or "Full wages were paid by the ER".)

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

	Temporary partial disability						
	Retraining benefits						

TPD and Retraining benefits:

- Each period of TPD or Retraining benefits should be listed separately on the form. A break in continuous dates of TPD or Retraining benefits constitutes a start of a separate period of benefits paid.
- Since TPD benefits are often paid at varying rates, you may list "varies" under rate or simply leave the space blank.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

	Permanent partial disability _____% ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ Part of body_____ (injuries before 01/01/1984)				

PPD:

- Enter the percent of PPD.
- Check the appropriate box for the date of injury and type of benefit being paid i.e. PPD, IC, or ERC.
- Enter the weeks and rate, if applicable, and total amount of PPD paid.

	Attorney fees/expenses		Benefit totals		
	M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)		
	M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)		
	Heaton fees paid		Interest paid		
	Roraff fees paid		**Total compensation paid** (include contingent attorney fees)		
	M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)		
	Other fees paid		Total medical expenses paid to date		
	Costs and disbursements paid				

Attorney Fee Expenses:

- Enter the amounts on the appropriate lines.

Note: When withheld fees are paid, remove them from the “withheld” line.

Totals:

- Enter the amounts on the appropriate lines.

Note: The starred items on the form should **not** be shown with attorneys fees deducted from the totals. Benefit totals shown on the form for these items should always include amounts withheld or paid for attorney fees.

	Insurer/self-insurer/TPA			Claim representative name		
	Address			Phone number (include area code)		Extension
	City	State	ZIP code	Date served on employee	Date served on employee’s attorney	

Bottom of the page:

- Fill in the insurer, claim representative's name, and phone number. No signature is required.

- The date served on employee is extremely important, especially when the discontinuance is for reasons other than return to work. Make sure this field is always filled in. The same applies to the date served on the employee's attorney, when applicable.

Notice of Benefit Reinstatement (NOBR)

The purpose of the NOBR form is to report payments to the department when there is a resumption in payments of wage loss benefits after they have been previously discontinued. It is also used to report other specific benefit payment changes on the claim.

The department uses this form to review for compliance with the statute and rules, and for statistical data.

Reasons to File

- To report a resumption of wage loss benefits, either voluntarily or pursuant to an order, after an NOID has been filed.

- To report a change of wage loss benefits being paid from TPD to TTD.

- To report a change from full wage continuation by the employer to insurer paid benefits.

Note: This form is not to be used to report the initial payment of wage loss benefits. The NOPLD form is used for this purpose.

When to File

- The form should be filed at the time of the payment.

How to Complete the Form

WID number or SSN	Date of injury (DOI)	Date of death (if applicable)
Employee (last, first, MI)		
Employer		
Insurer/self-insurer/TPA		
Insurer claim number		

The boxes in the upper left hand corner containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, Insurer, and Claim Number) must be fully completed each time the form is filed.

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment	Compensation rate
		☐ TTD ☐ TPD ☐ PTD ☐ DEP	Date from - Date through	

Fill in all fields of the next section (date of new payment, amount, etc.)

☐ 1. Payment resumed voluntarily. First date of new period of time lost _____ Date of notice to employer of new period of time lost _____
☐ 2. Payment resumed pursuant to order served and filed on _____ ☐ M.S. § 176.239 decision OR ☐ Other decision (OAH, WCCA or Supreme Court)
☐ 3. TPD changed to TTD effective _____
☐ 4. Full wage continuation changed to TTD effective _____

Explain why explain why benefits are being reinstated. Check Box 1-4 and fill in all the requested information in that box. **Only one box should be checked.**

Box 1 is used when payment is resuming voluntarily. Record the first date of new lost time as well as the date of notice to the employer of this lost time.

Box 2 is used when payment is resuming per an order. Record the date the order was served and filed and tell us what sort of decision it was.

Box 3 is used to report that TPD benefits are changing to TTD benefits. Record the date of this change in benefit type.

Box 4 is used to report that full wage continuation by the employer is changing to TTD benefits paid by the insurer. Record the date of this change.

Average weekly wage at DOI	Weekly value of:	Meals	Lodging	Second income
Explain below the reason for the change and attach a 26-week wage statement.				

The pre-injury wage information section needs to be completed only if the information differs from prior submissions. Otherwise, it can be left blank.

Claim representative name	Phone number (include area code)	Date

Fill in the claim representative's name and phone number, and the date this form is being sent. No signature is required.

Note: The insurer is not required to send a copy of this form to the employee or employer, but may wish to do so to keep them informed of the change.

Notice of Benefit Payment (NOBP)

The purpose of the NOBP form is two-fold. It is used to notify the employee about payment of PPD benefits or of a final benefit payment according to an award, decision, or order.

The department uses the form to review for compliance with the statute and rules, to verify calculation of benefits, and for statistical data.

Reasons to File

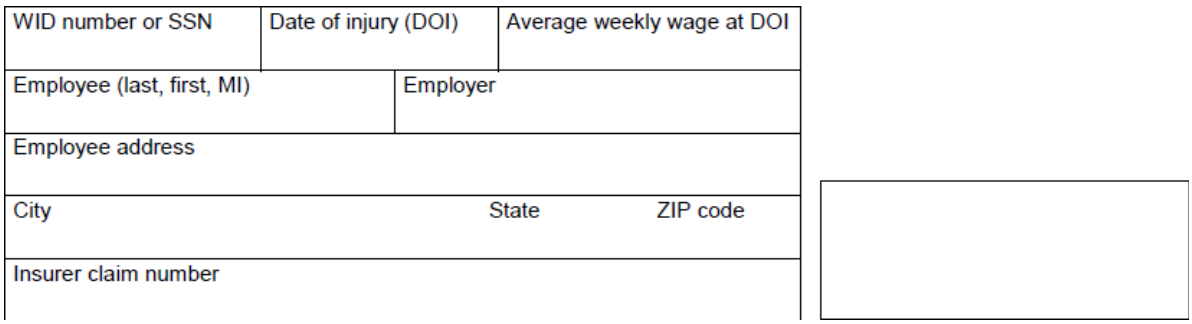
- When paying PPD in a lump sum.
- When making the first payment of periodic PPD benefits.
- When making the final payment of periodic PPD.
- When paying under an award, order or administrative decision.

When to File

- The form should be filed at the time the payment is made.

How to Complete the Form

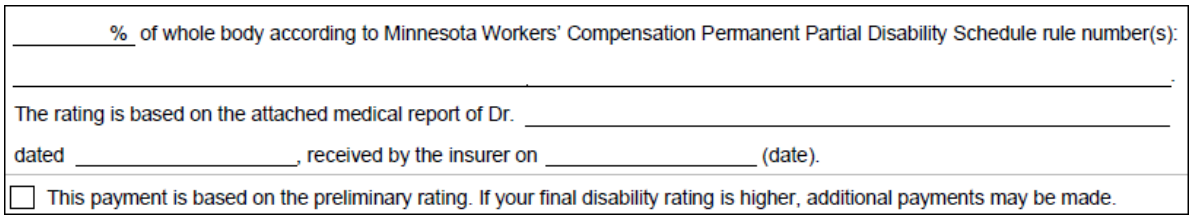
Front Page



The boxes in the upper left hand corner containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, Insurer, and Claim Number) must be fully completed each time the form is filed.

Check the box for **PPD** or **final payment.**

PPD



_____% of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):

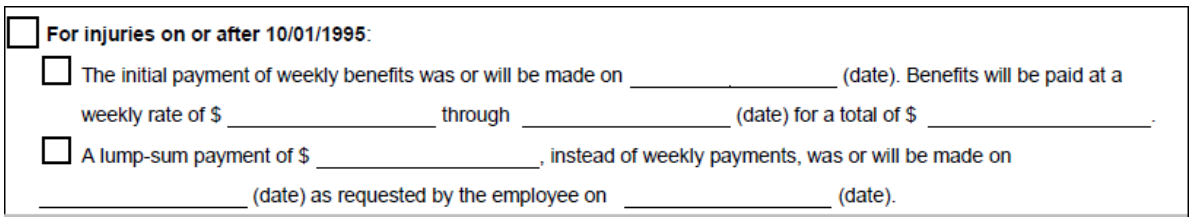
_____.

The rating is based on the attached medical report of Dr. _____

dated _____, received by the insurer on _____ (date).

☐ This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

- Enter the percent of PPD.
- Enter the rule number(s) from the PPD schedule, the name of doctor, and the date of medical report. *Attach the medical report giving the PPD rating.*
- Check the box if this is a preliminary payment.

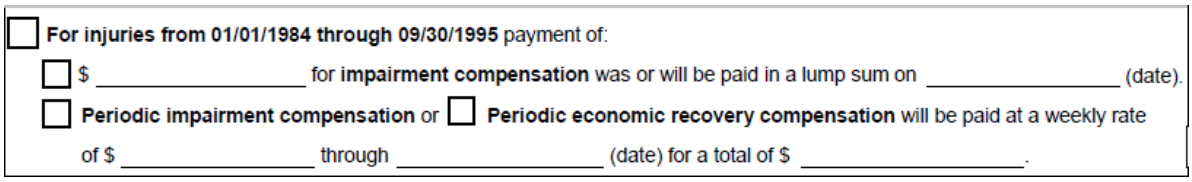


☐ **For injuries on or after 10/01/1995**:

☐ The initial payment of weekly benefits was or will be made on _____ (date). Benefits will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☐ A lump-sum payment of $ _____, instead of weekly payments, was or will be made on _____ (date) as requested by the employee on _____ (date).

For injuries occurring on or after October 1, 1995, enter the amount per week, beginning date, number of weeks, and total amount to be paid. For injuries on or after October 1, 2000, if paying in a lump sum as requested by the employee, indicate the lump sum being paid.



☐ **For injuries from 01/01/1984 through 09/30/1995** payment of:

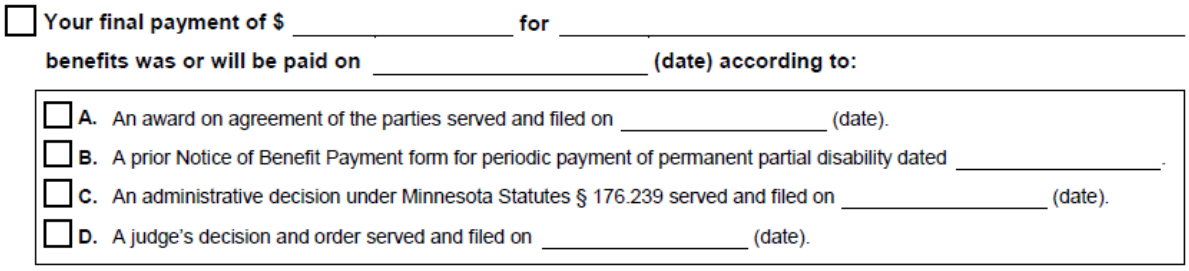
☐ $ _____ for **impairment compensation** was or will be paid in a lump sum on _____ (date).

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation** will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

For injuries between January 1, 1984 and September 30, 1995 for:

- Lump sum IC, indicate the dollar amount, date paid, and weeks of eligibility for Monitoring Period Compensation.
- Periodic IC or ERC, check box for type of benefit and enter the amount per week, beginning date, and number of weeks.

Final Payment



☐ **Your final payment of $ _____ for _____**

benefits was or will be paid on _____ (date) according to:

☐ **A.** An award on agreement of the parties served and filed on _____ (date).

☐ **B.** A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated _____.

☐ **C.** An administrative decision under Minnesota Statutes § 176.239 served and filed on _____ (date).

☐ **D.** A judge's decision and order served and filed on _____ (date).

Enter the amount of payment, type of benefit(s) being paid, and date the payment was or will be made.

Check the appropriate box A through D and indicate the date of the award, prior NOBP for PPD, or decision or order.

Amending NOID upon request of the department

☐ **Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on _____ (date).**

Check the box at the bottom of the NOBP if you are filing the form at the request of the Workers' Compensation Division as a follow-up to a question on a NOID.

Back Page

You are required to completely and accurately fill out the back side of the NOBP each time you file the form.

The following benefits have been paid	From	Through	Weeks	Rate	*Total
☐ Temporary total disability or ☐ Permanent total disability ☐ Benefit addendum attached					
Temporary partial disability					
Retraining benefits					

TTD and PTD:

- Check the appropriate box or boxes.
- Report each period of benefits paid on a separate line. Do not lump them together all on one line. A break in continuous dates of TTD or PTD or a change in the weekly payment rate constitutes a start of a separate period of benefits paid.
- On each line list the from date, through date, number of weeks paid, compensation rate, and total benefits paid for that period.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.
- Any important notes can be written in the box provided. (For example: "Employee works a 3-day week" or "Full wages were paid by the ER".)

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Temporary partial disability					
Retraining benefits					

TPD and Retraining benefits:

- Each period of TPD or Retraining benefits should be listed separately on the form. A break in continuous dates of TPD or Retraining benefits constitutes a start of a separate period of benefits paid.
- Since TPD benefits are often paid at varying rates, you may list "varies" under rate or simply leave the space blank.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Permanent partial disability _____% ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			

PPD:

- Enter the percent of PPD.
- Check the appropriate box for the date of injury and type of benefit being paid i.e. PPD, IC, or ERC.
- Enter the weeks and rate, if applicable, and total amount of PPD paid.

Attorney Fees/Expenses		Benefit Totals	
M.S. 176.081, subd. 1 & 3 Paid		*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld		Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid		Interest Paid	
Roraff Fees Paid		***TOTAL COMPENSATION PAID**	
M.S. 176.191 Paid		*Total Supplementary Benefits	
Other Fees Paid		**Total Medical Expenses Paid to Date**	
Costs & Disbursements Paid			

Attorney Fee Expenses:

- Enter the amounts on the appropriate lines.

Note: When withheld fees are paid, remove them from the "withheld" line.

Totals:

- Enter the amounts on the appropriate lines.

Note: The starred items on the form should **not** be shown with attorneys fees deducted from the totals. Benefit totals shown on the form for these items should always include amounts withheld or paid for attorney fees.

Insurer/self-insurer/TPA			Claim representative name		
Address			Phone number (include area code)		Extension
City	State	ZIP code	Date served on employee	Date served on attorney	

Bottom of the page:

- Fill in the insurer, claim representative's name and phone number, and the date the form is being served on the parties. No signature is required.

Interim Status Report (ISR)

The purpose of the ISR form is to notify the department of continuing compensation payments on long term claims.

The department uses the information supplied on the form to verify calculation of benefits and for statistical data.

Reasons and When to File

- Annually on all claims with ongoing payments of indemnity benefits and/or supplementary benefits.

- Filing the form on the anniversary date of the injury will help avoid calculation errors and is a good way to remember when to file this mandatory form.

How to Complete the Form

Front Page

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
INSURER CLAIM NUMBER	

The boxes in the upper left hand corner containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, and Claim Number) must be fully completed each time the form is filed.

☐ Temporary Total* ☐ Permanent Total*	FROM	THROUGH	WEEKS	RATE	*TOTAL
Balance Carried Forward					
				TOTAL:	

TTD and PTD:

- Check the appropriate box or boxes.
- Enter the balance carried forward from the last ISR, NOID, or NOBP filed.
- Report each new period of benefits paid on a separate line. Do not lump them together all on one line. A break in continuous dates of TTD or PTD or a change in the weekly payment rate constitutes a start of a separate period of benefits paid.
- On each line list the from date, through date, number of weeks paid, compensation rate, and total benefits paid for that period.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Temporary Partial	Balance Carried Forward					
					TOTAL:	

TPD:

- Enter the balance carried forward from the last ISR, NOID, or NOBP filed.
- Each new period of TPD should be listed separately on the form. A break in continuous dates of TPD or Retraining benefits constitutes a start of a separate period of benefits paid.
- Since TPD benefits are often paid at varying rates, you may list "varies" under rate or simply leave the space blank.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Permanent Partial Permanent Partial Disability _____% ☐ Injuries on or after 10/01/95 ☐ Impairment Compensation (injuries 01/01/1984 - 09/30/1995) ☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			
		TOTAL:	

PPD:

- Enter the percent of PPD.
- Check the appropriate box for the date of injury and type of benefit being paid i.e. PPD, IC, or ERC.
- Enter the weeks and rate, if applicable, and total amount of PPD paid.

Back Page

		FROM	THROUGH	WEEKS	RATE	TOTAL
Retraining Benefits	Balance Carried Forward					
					TOTAL:	
Dependency Benefits	Balance Carried Forward					
					TOTAL:	
Supplementary Benefits*	Balance Carried Forward					
					TOTAL:	

Retraining, Dependency, and Supplementary benefits:

- Enter the balance carried forward from the last ISR, NOID, or NOBP filed.
- Report each new period of benefits paid on a separate line. Do not lump them together all on one line. A break in continuous dates or a change in the weekly payment rate constitutes a start of a separate period of benefits paid.
- On each line list the from date, through date, number of weeks paid, compensation rate, and total benefits paid for that period.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Social Security Benefits or Other Government Benefits* ☐ Retirement ☐ Disability

Name of Program: _____

FROM	THROUGH	PER WEEK

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

Social Security/Government benefits:

- Check the box to indicate the type of program, retirement or disability, and provide the name of the program.
- Enter the dates and the amount per week.

Attorney Fees Paid		Interest Paid	
Attorney Fees Still Withheld		Lump Sum Payment Under Award or Order	
Attorney Fees Reimbursed to Employee M.S. 176.081, subd. 7		Total Compensation Paid to Employee	
		Total Dependency Benefits Paid (Please attached copy of worksheet)	

Attorney Fee Expenses:

- Enter the amounts on the appropriate lines.

Note: When withheld fees are paid, remove them from the "withheld" line.

Totals:

- Enter the amounts on the appropriate lines.

INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME
ADDRESS	PHONE NUMBER (include area code)
CITY STATE ZIP CODE	DATE SERVED

Bottom of the page:

- Fill in the insurer, claim representative's name and phone number, and the date the form is being served. No signature is required.

Notice of Discontinuance of Workers' Compensation Benefits Upon Death of Employee (NODUD)

The purpose of the NODUD form is to notify the parties that the insurer is discontinuing TTD, TPD, or PTD benefits based on the death of the employee.

The department uses the form to review for compliance with the statute and rules, to verify calculation of benefits, and for statistical data.

Reasons and When to File

- Within 14 days of the date the insurer receives notice of the death of an employee who is currently receiving TTD, TPD, or PTD benefits.

- This form is used in these situations instead of the NOID form.

Note: The timely filing of the form is very important because it triggers a letter sent by the department to any dependents or heirs alerting them of their rights.

How to Complete the Form

Front Page

WID or SSN	DATE OF INJURY
EMPLOYEE (last, first, mi)	EMPLOYER
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
INSURER CLAIM NUMBER	

The boxes in the upper left hand corner containing claim identifying information (WID/SSN, DOI, Employee Name, Employer, and Claim Number) must be fully completed.

THIS IS NOTIFICATION THAT WORKERS' COMPENSATION BENEFITS HAVE BEEN DISCONTINUED UPON THE DEATH OF THE EMPLOYEE ON _____ (date).

INSURER: PLEASE ANSWER THE FOLLOWING QUESTION(S)

1. Was the employee's death related to the work-related injury? ☐ YES ☐ NO ☐ UNKNOWN

   Insurer: If yes, please contact the heirs and dependents as soon as possible, and file a new First Report of Injury (with regard to the death) with the Workers' Compensation Division

2. If the employee was receiving periodic permanent partial disability, impairment compensation, or economic recovery compensation at the time of death, will this compensation continued to be paid to the heirs or dependents?

   ☐ YES If yes, for how long? _____

   ☐ NO If no, why not? _____

- Report the date of death.
- Indicate whether the death was related to the employee's injury by checking the appropriate box in question 1.
  - For yes, also file a new First Report of Injury for the date of death.
  - For no, attach to the form any supporting documentation (medical reports, death certificate, etc.) which help show the death was not related to injury.
  - For unknown, attach an explanation showing why it is unknown. (For example are medical reports not yet available or are there conflicting reports that need to be investigated?) The department will follow up if no further information is submitted.
- Indicate if periodic PPD will continue to be paid to the heirs or dependents and explain as needed.

Note: There are important instructions on the bottom of the page for any heirs or dependents of the employee.

Back Page

You are required to completely and accurately fill out the back side of the NODUD each time you file the form.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
☐ Temporary Total Disability or					
☐ Permanent Total Disability					
☐ Benefit Addendum Attached					

TTD and PTD:

- Check the appropriate box or boxes.
- Report each period of benefits paid on a separate line. Do not lump them together all on one line. A break in continuous dates of TTD or PTD or a change in the weekly payment rate constitutes a start of a separate period of benefits paid.
- On each line list the from date, through date, number of weeks paid, compensation rate, and total benefits paid for that period.
- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.
- Any important notes can be written in the box provided. (For example: "Employee works a 3-day week" or "Full wages were paid by the ER".)

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Temporary Partial Disability					
Retraining Benefits					

TPD and Retraining benefits:

- Each period of TPD or Retraining benefits should be listed separately on the form. A break in continuous dates of TPD or Retraining benefits constitutes a start of a separate period of benefits paid.
- Since TPD benefits are often paid at varying rates, you may list "varies" under rate or simply leave the space blank.

- If more lines are needed to complete the form accurately, use the **Benefit Addendum** form to show additional periods.

Note: Do not send printouts of all checks paid out in lieu of completing the required fields indicated above.

Permanent Partial Disability _____% ☐ Injuries on or after 10/01/95 ☐ Impairment Compensation (injuries 01/01/1984 - 09/30/1995) ☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			

PPD:

- Enter the percent of PPD.
- Check the appropriate box for the date of injury and type of benefit being paid i.e. PPD, IC, or ERC.
- Enter the weeks and rate, if applicable, and total amount of PPD paid.

Attorney Fees/Expenses		Benefit Totals	
M.S. 176.081, subd. 1 & 3 Paid		*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld		Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid		Interest Paid	
Roraff Fees Paid		***TOTAL COMPENSATION PAID**	
M.S. 176.191 Paid		*Total Supplementary Benefits	
Other Fees Paid		**Total Medical Expenses Paid to Date**	
Costs & Disbursements Paid			

Attorney Fee Expenses:

- Enter the amounts on the appropriate lines.

Note: When withheld fees are paid, remove them from the “withheld” line.

Totals:

- Enter the amounts on the appropriate lines.

Note: The starred items on the form should **not** be shown with attorneys fees deducted from the totals. Benefit totals shown on the form for these items should always include amounts withheld or paid for attorney fees.

INSURER/SELF-INSURER/TPA			CLAIM REPRESENTATIVE NAME	
ADDRESS			PHONE NUMBER (include area code)	EXTENSION
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY

Bottom of the page:

- Fill in the insurer, claim representative's name and phone number, and the date the form is being served on the parties. No signature is required.

Notice of File Closing

The purpose of this form is to notify the department that the insurer's file is about to be closed. Although filing of this form is not required by statute or rule, the voluntary use of it often avoids requests from the department to the insurer after their file has been closed and shipped to off-site storage.

The department uses the receipt of the form as a trigger to perform a final audit of the file for compliance with the statute and rules.

Reasons to File

- To notify department staff that the insurer is closing a file.

When to File

- At the time the insurer determines their file can be closed. Be sure that all required documents have been sent to the department before filing this form.

Health Care Provider Report (HCPR)

The purpose of the HCPR form is to request required medical information that is critical to proper administration of the claim. When requesting this information from a health care provider, a party must complete the general information section (at the top of the form) identifying the employee, the employer, and the insurer. Also, they must specify all items to be answered by the health care provider.

The health care provider must respond on this report form or in a narrative report that contains the same information within 10 calendar days of the request.

The health care provider is not reimbursed for providing the information on this form.

If the report indicates that the employee has reached MMI, the insurer must serve the report on the employee (see MMI in Section 1 for more information). If the report indicates a preliminary or final permanent partial disability rating, it must be filed with the department.

Report of Work Ability (RWA)

A health care provider treating an employee who alleges a work related injury must complete a RWA within 10 days of a request for a RWA from the insurer. In addition, the primary health care provider must provide a RWA to the employee at the following intervals (Minnesota Rules Part 5221.0410, Subp. 6):

- every visit if visits are less frequent than one every two weeks; or
- every two weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; or
- at expiration of the end date or review date specified in previous RWA.

The RWA must either be on the prescribed form or in a report that contains the same information.

The health care provider must provide the RWA to the employee and place a copy in the medical record.

It is not necessary to file the RWA with the department unless the report is the basis for a discontinuance of wage loss benefits or is needed to resolve a dispute.

Disability Status Report (DSR)

To ensure that a rehabilitation consultation is provided when necessary, Minnesota Rules Part 5220.0110, Subp. 7 requires that the insurer send the employee a DSR and file a copy with the department, when any of the following occur:

- within 14 calendar days of knowledge that the employee's TTD is likely to exceed 13 cumulative weeks; or
- within 90 calendar days of the date of injury when the employee has not returned to work following a work injury; or
- within 14 calendar days after receiving a request for a rehabilitation consultation, whichever is earlier.

In addition, a DSR must be filed within 14 calendar days of expiration of an approved waiver of rehabilitation services.

An insurer who files a DSR must refer the employee for a rehabilitation consultation or request a waiver of rehabilitation services. A rehabilitation waiver is granted when the employer documents that the otherwise qualified employee will return to suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for the waiver is filed. The waiver shall not be effective more than 90 calendar days after the waiver is granted. If the insurer is requesting a waiver, please note the *Instructions to Insurer* on the back of the prescribed DSR form. Documentation that the employee will return to suitable gainful employment is

satisfied by submitting a written offer of suitable gainful employment, signed by the employer, that is within the treating doctor's restrictions and to which the employee will return within 90 calendar days after the waiver is filed.

The department reviews all requests for waivers and notifies the insurer whether a waiver is granted or denied. If the department grants a waiver, it is only effective until 90 calendar days after the waiver is granted. A waiver of consultation and rehabilitation services may not be renewed.

If a waiver is not granted, the insurer must provide a rehabilitation consultation. When referring an employee to a QRC for a consultation, the insurer must send a copy of the DSR, the FROI, and the treating physician's RWA to the QRC prior to the consultation. If the insurer does not refer the employee for such a consultation, the department will order a consultation by the department's Vocational Rehabilitation unit or by the employee's choice of QRC.

Rehabilitation Consultation Report (RCR)

The rehabilitation consultation is a meeting between the employee and a QRC to determine whether the employee is eligible for rehabilitation services. According to Minnesota Rules Part 5220.0100, Subp. 22, an employee is eligible if, because of the effects of an injury or disease, whether or not combined with the effects of a prior injury or disability, the employee:

- is permanently precluded or is likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury;

- can not reasonably be expected to return to suitable gainful employment with the date-of-injury employer; and

- can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability.

During the consultation, the QRC must disclose any affiliations with the employer or insurer and must discuss the information on the "Rehabilitation Rights and Responsibilities of the Injured Worker" form.

To determine the employee's eligibility for rehabilitation services, the QRC talks not only with the employee, but also the employer and the treating doctor, when necessary. The QRC completes RCR which spells out the likelihood that the employee will return to the date-of-injury employer or date-of-injury job, and gives an assessment of whether or not the employee is a qualified employee for rehabilitation services. This form must be filed with the department within 14 days of the first in-person meeting with the employee. The QRC is required to provide copies of the RCR, a signed *Rehabilitation Rights and Responsibilities of the Injured Worker* form, and a narrative report explaining the basis for the determination to the employer, the employee, any attorney for the employee, and the insurer (see Minnesota Rules Parts 5220.0130, Subp. 3C(4) and 5220.0100, Subp. 31).

R-2 Rehabilitation Plan

The purpose of the plan is to communicate to all parties the vocational goal, the rehabilitation services to be provided, and the projected amounts of time and money needed to achieve the vocational goal. The QRC must complete a proposed plan and send it to the parties within 30 days of the consultation. Upon receipt of the proposed plan, each party must, within 15 days, either sign and return the plan to the QRC or promptly notify the QRC of any objection to the plan and work with the QRC to overcome this objection. If the objection is not resolved, the objecting party must file a Rehabilitation Request form with the department within the 15 days of receipt of the proposed plan.

A plan signed by all parties is considered approved upon filing with the department. If a party fails to sign the plan or file a Rehabilitation Request within 15 days, it shall be assumed that the parties are in substantial agreement with the plan's vocational objective and the rehabilitation services proposed.

R-3 Rehabilitation Plan Amendment

The QRC submits a Rehabilitation Plan Amendment whenever circumstances indicate that the plan's objectives are not likely to be achieved. The procedure for filing, approval, and requirements follow the same pattern for the plan amendments as for plans.

Plan Progress Report (PPR)

The PPR is used to inform parties of the current status of the plan and provide a current estimate of the plan cost and duration. The PPR must be filed with the department (with copies to parties) within 15 days after six months have passed from the date the plan was filed. If the QRC has filed a plan amendment 15 days before or after the six month time period, it is not necessary to also file the PPR.

On the Job Training

On the job training means training while employed at a workplace where the employee receives instruction from an experienced worker and which is likely to result in employment with the on the job training employer upon its completion.

When an on the job training plan is submitted to the department, the department reviews the proposed plan within 30 days of its submission and notifies the parties of plan approval or rejection. The plan approval process is subject to the procedures under Minnesota Rules Part 5220.0410, Subp. 6. The commissioner may make a determination or pursue resolution of disputes regarding the plan consistent with Minnesota Rules Part 5220.0950, Subp. 3.

Retraining

Retraining is training for a new occupation and obtaining the necessary skills to obtain work which produces an economic status as close as possible to what the employee would have enjoyed without disability. Retraining is to be given equal consideration with other rehabilitation services and may be proposed for approval if other considered services are not likely to lead to suitable gainful employment. When the QRC determines retraining to be appropriate, the QRC completes a Retraining Plan describing the recommended course of study and circulates it to the employee, employer, and insurer for their signatures.

When the QRC submits a Retraining Plan to the department with all three signatures, the department reviews the plan within a day or two of its submission, notifies the parties of its approval or denial and mails the Proof of Service to all parties with a signed copy of the Retraining Plan.

For injuries occurring from October 1, 1995 through September 30, 2000, a request for retraining of an employee must be filed with the department before the insurer has paid 104 weeks of temporary total and/or temporary partial disability benefits.

For injuries occurring from October 1, 2000 through September 30, 2008, a request for retraining of an employee must be filed with the department before the insurer has paid 156 weeks of temporary total and/or temporary partial disability benefits.

For injuries occurring on or after October 1, 2000, a request for retraining of an employee must be filed with the department before the insurer has paid 208 weeks of temporary total and/or temporary partial disability benefits.

The insurer must notify the employee in writing of this requirement, and this notice must be given before 80 weeks of temporary total and/or temporary partial benefits have been paid.

R-8 Notice of Rehabilitation Plan Closure

When an employee's rehabilitation plan is completed and closure of rehabilitation services is not disputed, the QRC must file a Notice of Rehabilitation Plan Closure along with a Closure Report summarizing services provided. When the reason for the closure is a return to work, the QRC may not complete and file the closure report until the employee has continued working for at least 30 calendar days following the return to work. This form must be filed with the department, with copies sent to the employee and the insurer.

At any time, the insurer or employee may request the closure or suspension of rehabilitation services by filing a "Rehabilitation Request" form. The commissioner or a compensation judge may close rehabilitation services for good cause, including, but not limited to the following reasons:

- denial of primary liability

- lack of medical causation
- employee is not cooperating with the plan
- employee is not likely to benefit from further rehabilitation services

Note: An insurer intending to discontinue rehabilitation benefits as well as TTD or TPD benefits must file a "Rehabilitation Request" form in addition to the NOID form.

Medical Request

A Medical Request form is used to request the department's help in resolving a workers' compensation dispute that involves medical issues. This form should not be used if the dispute involves rehabilitation, wage loss, or permanency benefits.

Parties involved in a medical dispute should try to resolve the dispute themselves prior to filing the request form. They can also call the department's Workers' Compensation Hotline, (651) 284-5032 or (800) 342-5354, for help in resolving the dispute informally.

Medical Requests are usually filed by employees or healthcare providers to get approval for payment of a medical service which was denied by the insurer. An insurer may also file such a request to resolve a dispute over treatment. This form is also filed to a request for a change of treating doctor. Be sure to fill out the name of the current treating doctor and the name of the doctor to whom treatment should be switched. If the employee is requesting a change of doctor and the insurer agrees, this form does not need to be filed. Medical Responses are filed within 20 days after the Medical Request is filed.

If the dispute involves surgery or medical services exceeding $7,500.00, the request is automatically referred to OAH for a formal hearing. The $7,500.00 limit does not apply if the issue is whether the charge is excessive. Otherwise, the matter will be set for an administrative conference with a mediator at the department.

Medical Response

If the employee or health care provider has filed a Medical Request form, the insurer must file a Medical Response form with the department and serve copies on the other parties no later than 20 days after service of the Medical Request.

Once the department processes both the Medical Request and the Medical Response, a legally binding written decision may be made based on the information submitted on the forms. It is important that the insurer make their response as complete as possible.

Rehabilitation Request

A Rehabilitation Request form is used to request the department's help in resolving a workers' compensation dispute that involves rehabilitation issues. This form should not be used if the dispute involves medical, wage loss, or permanency benefits.

Parties involved in a rehabilitation dispute should try to resolve the dispute themselves prior to filing the request form. They can also call the department's Workers' Compensation Hotline, (651) 284-5032 or (800) 342-5354, for help in resolving the dispute informally.

Typical disputes filed by insurers include requesting that a plan be changed or terminated. For example, the insurer could file a Rehabilitation Request form if the QRC believes the employee should be retrained and they believe it is not necessary. If the insurer submits a request to terminate the rehabilitation plan, they must send the employee a Rehabilitation Response form with the employee's copy of the request.

Rehabilitation Response

If another party has filed a Rehabilitation Request form, the responding party should file a Rehabilitation Response form in a timely manner. The department expedites the processing of all Rehabilitation Requests and will begin to intervene immediately.

Request for Formal Hearing

When a party wishes to appeal a medical or rehabilitation decision and order per Minnesota Statutes §176.106, this form must be filed within 30 days after the decision and order was served on the parties.

Objection to Penalty Assessment

When a party wishes to object to a penalty assessment, this form must be served on the parties and with the department within 30 days after the notice of penalty assessment was served on the parties. See Section 5 for further details on how and when to file this form.

Forms Filing Table

(when to file common forms with the department)

FORM #	FORM NAME	AKA	WHEN TO FILE
Indemnity Benefits			
FR01	First Report of Injury	FROI	This form must be filed **by the insurer** if the injury results in claimed disability for a period of more than three calendar days or results in PPD: • within 14 days of the first day of disability, or the date the employer was aware of the disability, whichever is later; • within 10 days of a request from the department, to complete a substitute filing of this form if the employer is unable or refuses to file this form. This form must be filed if any other required form is filed and no FROI has previously been filed. **This form must also be filed within 21 days upon specific request from the department.**
NL01	Notice of Insurer's Primary Liability Determination	NOPLD	This form must be filed by the insurer when, after reviewing the FROI, there appears to be claimed disability beyond the waiting period. **When accepting liability** and making payment of wage loss benefits, this form must be filed whenever the following occurs: • liability is accepted and the initial payment is made for TTD, TPD, or PTD benefits; • liability is accepted for wage loss benefits and the employer has a full wage plan; • liability is accepted and payment is made on a fatality. The ***first payment must be made*** within 14 days of the first day of disability, or the date the employer was aware of the disability, whichever is later. **When partially accepting liability** but not making payment of wage loss benefits, this form ***must be served on the employee and filed the department*** within 14 days of the first day of the disability or the date the employer was aware of the disability, whichever is later, whenever the following occurs: • liability is accepted but denial of the initial claimed disability is determined; or • liability is accepted for temporary partial benefits and payment will be made in the future, upon receipt of wage loss information. **When denying primary liability**, this form ***must be served on the employee and filed the department*** within 14 days of the first day of the disability or the date the employer was aware of the disability, whichever is later. **This form must also be filed within 21 days upon specific request from the department.** **NOTE: NOPLDs may be filed multiple times on a claim.**
ND01	Notice of Intention to Discontinue WC Benefits	NOID	This form must be filed by the insurer to reduce or discontinue TTD, TPD, or PTD benefits: • within 14 days of the date the insurer receives notice that the employee has returned to work at full or reduced wages;

FORM #	FORM NAME	AKA	WHEN TO FILE
			• at the same time that benefits are reduced or discontinued for reasons other than return to work; • when discontinuing benefits and denying primary liability on a previously accepted claim when it is more than 90 days from the first day of disability or the date the employer was aware of disability, whichever is later. **This form must also be filed within 21 days upon specific request from the department.**
NC01	Notice of Benefit Reinstatement	NOBR	This form must be filed by the insurer at the time TTD, TPD, or PTD benefits are reinstated, TPD benefits are changed to TTD benefits, or payment of wage continuation by the employer for TTD or TPD is changed to TTD or TPD paid by the insurer. **This form must also be filed within 21 days upon specific request from the department.**
NB01	Notice of Benefit Payment	NOBP	This form must be filed by the insurer at the time the initial and final PPD payments are made or when a final payment is made per award or order. **This form must also be filed within 21 days upon specific request from the department.**
IS03	Interim Status Report	ISR	This form must be filed by the insurer annually, for as long as indemnity benefits continue, at one year after the last payment form was filed with the department. **This form must also be filed within 21 days upon specific request from the department.**
BD02	Notice of Discontinuance of WC Benefits Upon Death of Employee		This form must be filed by the insurer to discontinue TTD, TPD, or PTD benefits as soon as the insurer learns of the death of the employee. **This form must also be filed within 21 days upon specific request from the department.**
DB02	Notice of Discontinuance of Dependency Benefits		This form must be filed at the time the insurer reduces or stops payment of dependency benefits. **This form must also be filed within 21 days upon specific request from the department.**
BA01	Benefit Addendum		This form should only be filed when the insurer needs additional space when filing one of the following forms: NOID, NOBP, ISR, or NODUD.
QE03	Request for Extension		This form may be filed by the insurer within 14 days of notice to or knowledge by the employer of a new period of TTD that is related to a **prior paid claim.**
Medical			
HC01	Health Care Provider Report	HCPR	This form is completed by the primary health care provider and must be filed by the insurer when there is a preliminary or final permanent partial disability rating. The completed form may be filed by the insurer when the employee has reached maximum medical improvement. **This form must also be filed within 21 days upon specific request from the department.**
RW01	Report of Workability	RWA	This form must be completed by the primary health care provider every two weeks or at every visit if visits are less frequent and given to the employee (but not filed with the

FORM #	FORM NAME	AKA	WHEN TO FILE
			department). The employee provides the RWA to the employer or insurer.
MQ03	Medical Request		This form may be filed by any party when there is a dispute involving medical issues.
MR03	Medical Response		This form is filed within 20 days after service of the medical request or within the time period provided by Minnesota Rules Part 5221.6050, Subp. 7.
Rehabilitation			
DS01	Disability Status Report	DSR	This form must be filed by the insurer within 14 days of knowledge that the TTD will likely exceed 13 weeks **or** within 90 calendar days of the date of injury when the employee has not returned to work after the injury **or** within 14 calendar days after receiving a request for a rehabilitation consultation, whichever comes first. **This form must also be filed within 21 days upon specific request from the department.**
RC01	Rehabilitation Consultation Report	RCR	This form must be filed **by the QRC** within 14 days of the first in-person meeting with employee A signed copy of the "Rights and Responsibilities of the Injured Worker" as well as an assessment of whether or not the employee is a qualified employee for rehabilitation services should be filed with the RCR.
IW05	Rights and Responsibilities of the Injured Worker		Needs to be filed with the RCR.
RE01	R-2 Rehabilitation Plan	R-2	This form must be filed **by the QRC** within 45 days of the first in-person contact with employee or within 15 days of circulation of the parties, whichever is earlier. A copy of the QRC's initial evaluation narrative report must also be filed with the R-2.
RP01	R-3 Rehabilitation Plan Amendment	R-3	This form must be filed **by the QRC** within 15 days of circulation to the parties.
PR01	Plan Progress Report	PPR	This form must be filed **by the QRC** within 15 days after 6 months have passed from date of filing of the rehabilitation plan. An R-3 may be used in lieu of the PPR if filed within the same time period.
JA04	On the Job Training Plan	OJT	This form must be filed **by the QRC** to submit on the job training plan for approval. The department shall review the proposed plan within 30 days of its submission and notify the parties of the plan's approval or rejection.
EP04	Retraining Plan		This form must be filed **by the QRC** to submit a retraining plan for approval. The department shall review the proposed retraining plan within 30 days of its submission and notify the parties of the plan's approval or denial.
NR01	R-8 Notice of Rehabilitation Plan Closure	R-8	This form must be filed **by the QRC** within 30 calendar days of knowledge that:

FORM #	FORM NAME	AKA	WHEN TO FILE
			1) the employee has been steadily working at suitable gainful employment for 30 days or more, or the time period provided in the plan. 2) the employee's rehabilitation benefits have been closed out by an award on stipulation or an award on mediation. 3) the employee and insurer have agreed to close the rehabilitation plan. 4) the QRC has been unable to locate the employee following a good faith effort to do so. 5) the employee has died. 6) the commissioner or a compensation judge has ordered that the rehabilitation plan be closed and there has been no timely appeal of that order. 7) the QRC decides to withdraw after the insurer has provided written notice to the employee, the employee's attorney, the department, and the QRC that the insurer is denying further liability for the injury for which rehabilitation services are being provided.
RQ03	Rehabilitation Request		This form may be filed by any party when there is a dispute involving rehabilitation issues.
RR03	Rehabilitation Response		If the Rehabilitation Request is filed by the employee or QRC, the insurer must file a Rehabilitation Response within 10 days after being served with the Rehabilitation Request.
Miscellaneous			
CE0003	Objection to Penalty Assessment		When a party wishes to object to a penalty assessment, this form must be served on the parties and filed with the department within 30 days after the notice of penalty assessment was served on the parties.
CA0022	Request for Certification of Dispute		This form must be filed by the employee's attorney, prior to filing a medical or rehabilitation request form, to allow the department to certify that a medical or rehabilitation dispute exists. **Exception:** It is not needed when there is other pending litigation.
RF03	Request for Formal Hearing		When a party wishes to appeal a medical or rehabilitation decision and order per Minnesota Statutes §176.106, this form must be filed within 30 days after the decision and order was served on the parties.
NF01	Notice of File Closing		This form may be filed at the time the insurer determines their file can be closed. Be sure all required documents have been sent to the department before filing this form.