Reset

Mail completed copy to:

Department of Labor and Industry
Claims Services and Investigations
PO Box 64229
St. Paul, MN 55164-0229
(651) 284-5045 or
1-800-342-5354 (DIAL-DLI)
Fax: (651) 284-5733

Annual Claim for Reimbursement from the Second Injury Fund

PRINT IN INK or TYPE your responses
All dates must be entered in MM/DD/YYYY

A R 0 4

FOR CSI USE ONLY

WID or SSN	DATE OF INJURY

EMPLOYEE NAME	INSURER/SELF-INSURER (Reimbursement Payable To)
EMPLOYER NAME	INSURER/ ADDRESS
INSURER CLAIM NUMBER	CITY STATE ZIP CODE

Claim status

☐ A. **First claim for this date of injury**

☐ AA. **First and last claim** based upon full, final and complete settlement

☐ B. **Continuing** - Attach **EVIDENCE** of contact with employee during the time period which **SUPPORTS ELIGIBILITY** for benefits (i.e., status check confirming employee remains disabled, medical and/or rehabilitation reports from the time period claimed, etc.).

☐ C. **Final Claim** for this case. Reason:

☐ 1) Returned to work on: _____

☐ 2) Death of employee on: _____ **ATTACH DEATH CERTIFICATE**

☐ 3) Indemnity and/or medical closed by settlement

☐ 4) Other: Explain:

YOU MUST COMPLETE THE BACK SIDE OF THIS FORM.

Name of Preparer	Date
Company Name (if different from above)	Phone No. (include area code & ext.)
Address	

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

MEDICAL AND REHABILITATION EXPENSE DETAIL

Attach detailed description/itemization of rehabilitation and/or medical expenses. Include the dates of service, dates paid, amounts paid and names of providers. (Computerized printouts are sufficient if they include all required information.)

These medical expenses ☐ do **NOT** exceed ☐ **DO** exceed permissible limits set for medical services in Minnesota Rules Chapter 5221. If the medical fee schedule has not been applied to any bills for medical services, **ATTACH A COPY OF THE BILL SHOWING THE CPT CODE.**

DATES for which you are requesting reimbursement _____ **through** _____

1. a. Medical and rehabilitation expenses claimed this period _____

   b. Less deductible to this date of injury - _____

   SUBTOTAL _____

   c. Percent apportioned **(Attach proof of apportionment if claiming for the first time)** _____ %

   SUBTOTAL _____

   d. Lump sum amount to be reimbursed

   e. **TOTAL Medical and Rehabilitation** expenses claimed $ _____

INDEMNITY EXPENSE DETAIL

Complete an Interim Status Report for the period covered by this claim. **Transfer** the information from the **Interim Status Report.**

DATES for which you are requesting reimbursement _____ **through** _____

2. a. Temporary Partial Benefits paid _____

   Retraining Benefits paid _____

   Temporary Total Benefits paid _____

   Permanent Total Benefits paid _____

   SUBTOTAL _____

   b. Less deductible to this date of injury - _____

   SUBTOTAL _____

   c. Percent apportioned **(Attach proof of apportionment if claiming for the first time)** _____ %

   SUBTOTAL _____

   d. Permanent Partial, Impairment Compensation, Economic Recovery claimed **(circle type of permanency paid)** _____

   e. Lump sum to be reimbursed

   f. **TOTAL indemnity** reimbursement claimed $ _____

3. **TOTAL reimbursement claimed (1e + 2f)** $ _____

CLAIMS SERVICES AND INVESTIGATIONS USE ONLY

Indemnity Amount Approved $ _____

Medical Amount Approved $ _____ Adjustment Code _____

Amount Adjusted $ _____ Approved by _____

Total Approved $ _____ Date Approved _____

Paid by _____ Date Paid _____

Vendor Number _____ Batch Number _____