LYON COUNTY HUMAN RESOURCES
27 South Main Street
Yerington, Nevada 89447
Phone: (775)463-6510 **Fax**: (775)463-6500

INJURED WORKER PACKET

- **If injury arises out of and in the course of employment** – As soon as practicable and in no event later than 7 days of the injury, complete the "Notice of Injury or Occupational Disease" form (labeled C-1) in this packet. Have your supervisor sign the C-1 form and send to Human Resources.

- **If you need medical attention** – Please see the list of in-network occupational health centers in this packet. For non-emergent medical care, please go to a provider on the list. For emergency medical care, call 911 or go to the nearest emergency room. If you are unsure if you need medical attention - call the Nurse Triage 24/7/365 at 844-334-6472.

- If you're injured at work and would like to be seen at ROC or Swift Institute for an **orthopedic issue**, you must first call the 24/7 Nurse Triage line at (844) 334-6472.

- **If after receiving medical attention you are** –

    1. **Released to full duty** – Provide the written release (or completed C-4 form) to HR and your supervisor.

    2. **Released with restrictions** – Provide the written restrictions to HR and your supervisor. Your supervisor/department head will determine if your restrictions can be accommodated with modified duty. If so, you will receive a written offer of temporary modified duty.

    3. **Released but referred for follow-up care** – Promptly advise HR. You will be assigned a new leave pay code to use in situations where the follow-up appointments require you to miss normally-scheduled work time. This pay code is *not* to be used for appointments outside of your scheduled work hours.

    4. **Not released to work and/or modified duty is not available –** HR will contact you regarding leave usage and applicable wage-replacement benefits during your absence (summarized below). During your absence, promptly provide any medical updates and doctor's notes to your supervisor.

    5. **Prescribed medication** – It is very important to use the "Temporary Prescription Benefit Card" in this packet. Do *not* use your Cigna insurance card.

- **Wage-replacement benefits** –

    1. **For absences less than 5 days** – You may use sick or vacation leave for any scheduled work time that you miss.

    2. **For absences of 5 or more days** – HR will contact you regarding your options.

- **FMLA** – You will be placed on FMLA leave if you are eligible. The FMLA is a federal law that applies to all serious health conditions (occupationally-related or otherwise). Where the FMLA and the state workers' compensation laws both apply, they run contemporaneously. The FMLA protects your job during your absence, and more information about it can be found in Section 9.4 of Lyon County's Personnel Policy Manual and the United States Department of Labor's website.

Expedited Orthopedic Workers' Compensation Consultation

What is Expedited Workers' Compensation Processing?

Expedited orthopedic workers' compensation consultations are now available at select **Swift Institute** locations and **ROCx**. Streamlining the C4 completion and skipping primary care visits allow injured workers to direct access to the orthopedic pipeline. This process allows for expedited paperwork completion, reduced waiting times, and increased communication between the injured worker, employer, and insurance carrier—ultimately returning the injured employee back to work in less time.

Benefits of Expedited Processing

- **Skip the primary care visit:** By being triaged directly to the orthopedic urgent care, the worker is spared visits to primary care to get referrals.
- **Reduced stress:** Expedited processing can help reduce the emotional stress associated with the claims process.
- **Improved employee morale:** A timely and efficient claims process can boost employee morale and job satisfaction.
- **Cost savings:** Expedited processing can help reduce the overall cost of workers' compensation claims.

How Does Expedited Processing Work?

1. **Immediate reporting:** Promptly report the injury to your employer and follow their procedures for filing a claim.
2. **Nurse Triage 24/7/365 call line 844- 334-6472:** Nurse triage will make recommendations to the injured worker and refer them to orthopedic urgent care when necessary.
3. **Orthopedic Urgent Care:** Injured workers can go directly to Swift Institute or ROCx (after calling 24/7/365 call line at 844-334-6472) to have their C-4 filled out and get into the orthopedic pipeline.
4. **Early intervention:** Allows the injured worker to schedule follow-up appointments and imaging in a timelier manner.

By understanding the expedited workers' compensation orthopedic consultation process and taking proactive steps, you can help ensure a smoother and more efficient experience.

Workers' Compensation

CLAIMS PROCESSING TIME FRAMES

All forms are available on the WCS website: http://dir.nv.gov/wcs/home/

C-1 Form Notice of Injury or Occupational Disease - Incident Report NRS 616C.015	Employee should complete within 7 days after the accident; must be maintained by employer for 3 years; employer required to keep adequate supply of blank forms for employee use.
C-3 Form Employer's Report of Industrial Injury or Occupational Disease NRS 616C.045	Employer must complete and file with the insurer within 6 working days after receiving a copy of the C-4 Form. Insurer/TPA should supply forms to employer.
C-4 Form Employee's Claim for Compensation/Report of Initial Treatment NRS 616C.040	Physician or chiropractor must complete and file with employer and employer's insurer within 3 working days of treatment.
Claim Determination NRS 616C.065 NRS 616D.120-150	Insurers have 30 days after accident notification (or 30 working days after claim receipt for occupational disease): • Accept the claim & notify claimant or claimant's rep of acceptance • Begin payment on the claim • Or deny the claim and notify claimant or claimant's rep and DIR of denial • Insurer's notification must be documented with a certificate of mailing.
D-8 Form Employer's Wage Verification Form NRS 616C.045 & NRS 616A.480	Employer must complete and file with the insurer within 6 working days of receipt of the C-4 (if the C-4 indicates the injured employee will be off work for 5 consecutive days or more or 5 days in a 20 day period) or when requested by the insurer. Insurer/TPA should supply forms.
Blank Forms NRS 616A.480	Employer must fully complete any blank form received by the insurer or the administrator and return to appropriate party within 6 working days. Maximum fine of $1,000 per occurrence
Filing a claim for compensation NRS 616C.020	An injured employee shall file a claim for compensation with the insurer within 90 days after an accident if: (a) The employee has sought medical treatment for an injury arising out of and in the course of his employment; or (b) The employee was off work as a result of an injury arising out of and in the course of his employment. In the event of the death of the injured employee resulting from the injury, a dependent of the employee, or a person acting on his behalf, shall file a claim for compensation with the insurer within 1 year after the death of the injured employee.

For additional information on Worker's Compensation, contact the Human Resources Department
OR
visit the Nevada Worker's Compensation website: http://dir.nv.gov/wcs/home/

Print Form

Reset Form

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee	Social Security Number	Telephone Number

Date of Accident (if applicable) _____

Time of Accident (if applicable) _____

Place where accident occurred (if applicable) _____

What is the nature of the occupational disease?

List any body parts involved:

Briefly describe accident or circumstances of occupational disease:

(**Note:** if you are claiming an occupational disease, indicate the date of which the employee first became aware of the connection between the condition and employment)

Name of witnesses:

Did the employee leave work because of the Injury or occupational disease? ☐ Yes ☐ No

If yes, when (date and time) _____

Has the employee returned to work? ☐ Yes ☐ No

If yes, when (date and time)? _____

Was first aid Provided? ☐ Yes ☐ No

If yes, by whom? _____

Name and address of treating physician if applicable or known:

Did the accident happen in the normal Course of work? ☐ Yes ☐ No

Was anyone else involved? ☐ Yes ☐ No

Names of other involved:

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGES TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature _____ Date _____

Signature of Injured or Disabled Employee _____ Date _____

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4)

For assistance with Workers' Compensation Issues, you may contact the State of Nevada Office for Consumer Health Assistance
Toll Free: 1-888-333-1597 - Web site: http://dhhs.nv.gov/Programs/CHA/ - E-mail: cha@govcha.state.nv.us

Employee should sign, date and retain a copy of this form.

Original to Employer, Copy to Employee

C-1 (Rev. 02/20)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C 4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Lyon County	County Gov't	88-6000097	

Office Mail Address	Location . . . If different from mailing address	Telephone
27 S. Main St		
City State Zip	**INSURER**	**THIRD-PARTY ADMINISTRATOR**

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken

Home Address (Number and Street)	Email Address	Sex ☐ Male ☐Female	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No	How long has this person been employed by you in Nevada?

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:

Telephone	Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No	Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported

Address or location of accident (Also provide city, county, state) (if applicable)	Accident on employer's premises? (if applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected / If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	
	Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason	Location of Initial Treatment	
Treating physician/chiropractor name	Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No

IMPORTANT How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐	Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the State of Nevada Office of the Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only)

Mailing Address	Age	Height	Weight	Social Security Number

City	State	Zip	Telephone

Email Address	Primary Language Spoken

INSURER	**THIRD-PARTY ADMINISTRATOR**	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name	Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?	Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date Place Employee's Original or * Electronic Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place Name of Facility

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Treatment:	Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty If modified duty, specify any limitations/restrictions: _____
X-Ray Findings:	
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No	
Is additional medical care by a physician indicated? ☐ Yes ☐ No	

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Health Care Provider's Name	I certify that the employer's copy of this form was delivered to the employer on:

Address			INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature		Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)	

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street**,** Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 3360 West Sahara Avenue, Suite 250, Las Vegas, Nevada 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

Alternative Service Concepts
Loyalty • Integrity • Flexibility • Expertise

mitchell

Mitchell ScriptAdvisor

"How to Guide" for Workers' Compensation *FIRST FILL* (Temporary Prescription Card)

Mitchell ScriptAdvisor has been selected to assist your injured employee in obtaining prescription drugs related to their workers' compensation claim.

This attached ***"FIRST FILL"*** letter enables your injured employee to fill prescriptions written by an authorized workers' compensation physician for medications related to their injury at the time of first reporting.

Utilization of the card should ensure that your employee has **NO out-of-pocket expenses** when filling their first prescription ("*first fill*").

In addition, the attached "first fill" letter provides your injured employee instructions on how to utilize this *temporary prescription card for interim prescription filling* until a permanent prescription benefit card is established.

The only action items required to ensure your injured employee receive this letter at first report of their injury would be:

1. Make physical copies of this ***First Fill*** letter for any workers' compensation injury
2. Provide this letter to your injured employee via:
    - First Report of Injury Packet
    - Email
    - Website (loaded prior)
    - Hand directly to injured employee
3. Point out to the injured employee to take the *First Fill* letter to their local pharmacy *(instructions provided on First Fill letter)*

Should you have any additional questions, please contact:

Pamela Finch, Chief Operations Officer
Two Rivers Corporate Centre, Suite 802
2501 McGavock Pike, Nashville, TN 37214
Office phone: (615) 360-0247
pam.finch@ascrisk.com

Mitchell ScriptAdvisor

First Fill – Temporary Prescription Card

Alternative Service Concepts

Mitchell ScriptAdvisor (formerly known as PMOA) has been selected by Alternative Service Concepts to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number or visit our website at www.mitchellscriptadvisor.com use the pharmacy locator.

Employee

- You may contact Customer Service at 866.846.9279 OR you may simply hand this document to the Pharmacy/Pharmacist to request activation of your Temporary Prescription ID
- Fill in the ID number supplied by Mitchell Customer Service along with your name on the ID card below.

Pharmacy

- To obtain the temporary Prescription ID, please contact Customer Service at 866.846.9279
- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Member Name:

Member ID #:

Rx BIN: 019082

PCN: MPS

Questions? Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury-related injuries covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

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Occupational Health Center	Address	City	State	Zip	Phone
Carson Tahoe Medical Center	1600 Medical Pkwy	Carson	NV	89703	(775) 445-8733
Concentra	3488 Goni Rd., Bldg E. #141	Carson City	NV	89706	(775) 887-5030
Dayton Urgent Care	901 Medical Center Drive	Dayton	NV	89403	(775) 445-7210
Elko Clinic	1995 Errecart Blvd. #102	Elko	NV	89801	(775) 738-3111
A+ Urgent Care	976 Mountain City Hwy	Elko	NV	89801	(775) 777-7587
Banner Churchill Hospital	801 E. Williams Ave.	Fallon	NV	89406	(775) 423-3151
Renown Medical Group Urgent Care	560 E. Williams Ave.	Fallon	NV	89406	(775) 982-5000
Renown Health Urgent Care	1343 W. Newlands Dr.	Fernley	NV	89408	(775) 982-6529
Carson Tahoe Medical Center	1107 Hwy 395 South, Suite C	Gardnerville	NV	89410	(775) 782-1615
Incline Village Urgent Care	930 Tahoe Blvd, #207	Incline Village	NV	89451	(775) 833-2929
Incline Village Community Hospital	880 Alder Ave.	Incline Village	NV	89451	(775) 833-4100
Reno Orthopedic Clinic	555 No. Arlington Street	Reno	NV	89501	(775) 786-3040
Northern Nevada Medical Group	5575 Kietzke Lane	Reno	NV	89511	(775) 851-1505
Family Medicine Concentra	6410 S. Virginia	Reno	NV	89511	(888) 997-2669
Specialty Health Clinic	330 E. Liberty St., #100	Reno	NV	89501	(775) 398-3630
St. Mary's Urgent Care - Primary Care Plus	18653 Wedge Pkwy., #300	Reno	NV	89511	(775) 770-7210
St. Mary's Urgent Care - Primary Care Plus	1595 Robb Dr., #2	Reno	NV	89523	(775) 770-7580
Concentra Medical Centers	6410 So. Virginia Street	Reno	NV	89511	(775) 322-5757
Renown Health Medical Group	75 Pringle Way	Reno	NV	89502	(775) 982-4100
St. Mary's Regional Medical Center	235 W. 6th St.	Reno	NV	89503	(775) 770-3000
Renown South Meadows	10101 Double R Blvd	Reno	NV	89521	(775) 982-7280
Renown Silver Springs	3595 US-50	Silver Springs	NV	89429	(775)577-2117
Family Medicine Northern Nevada Medical Group	5975 Los Altos Pkwy #100	Sparks	NV	89436	(775) 851-1505
ARC Health & Wellness Centers	2205 Glendale Ave., #131	Sparks	NV	89431	(775) 331-3361
Concentra Medical Centers	225 Glendale Ave., #12	Sparks	NV	89431	(775) 356-8181
St. Mary's Urgent Care - Primary Care Plus	5070 Ion Dr., #100	Sparks	NV	89436	(775) 770-7580
Northern Nevada Medical Center	2375 E. Prater Way, #205	Sparks	NV	89434	(775) 356-4888
Renown Health Urgent Care	910 Vista Blvd.	Sparks	NV	89434	(775) 982-4583
Smith Valley Physicians Clinic	445 St. Rte 338	Wellington	NV	89444	(775) 465-2587
Humboldt General Hospital	118 E. Haskell St.	Winnemucca	NV	89445	(775) 623-5222
South Lyon Medical Center	213 S. Whitacre	Yerington	NV	89447	(775) 463-2301