INSTRUCTIONS FOR COMPLETING WORK INJURY SUPPLEMENTAL BENEFIT FUND BARRED CLAIM

Pursuant to the mandatory reporting requirements for the Department of Workforce Development, Division of Worker's Compensation, as a Responsible Reporting Entity under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 this completed claim form must be filed with a WKC-7 Hearing Application for all barred traumatic or occupational injury claims made against the Work Injury Supplemental Benefit Fund. It can be mailed to the Worker's Compensation Division, P. O. Box 7901, Madison, WI 53707-7901 (or filed in person at the State Office Building, 201 East Washington Ave., Room C100, Madison, WI).

If at any time you need more space than is provided on the claim form, use a separate sheet of paper to provide the required information. To avoid confusion, note on the claim form that the required information is on an attached sheet(s) and place the question box number and the applicant's Social Security Number on the additional sheet(s). Specific instructions follow.

Boxes 1 - 9 - Employee Information

The employee information sections should be completed with information about the injured worker. Please ensure that questions 8 and 9 are filled out.

Box 10 - Date of Injury

Example: 7/15/2009. In the case of traumatic injuries, this would be the actual date of the accident or incident. If there is more than one date of injury for a particular employer, indicate all dates in the space provided, or on an additional sheet if necessary.

In the case of occupational hearing loss, the injury date would be the date of either: (a) transfer to non-noisy employment, (b) last day worked before retiring, (c) termination of employer-employee relationship, or (d) layoff if at least 6 months.

In the case of occupational disability exclusive of hearing loss; the date of injury would be the date of disability or if disability occurs after cessation of employment, the last day of work for the last employer whose employment caused disability.

Box 11 - CMS Date of Incident

Example: 6/15/1982. Per the reporting requirements as laid out by the Centers for Medicare & Medicaid Services (CMS) Non-Group Health Plan User Guide v3.2: (1) for traumatic injuries the date of incident is the *date of the injury*; (2) for exposure claims (such as occupational hearing loss and diseases such as asbestosis) the date of incident is the *date of first exposure*; (3) for claims involving implants it is the *date of the implant* (or *date of the first implant if there are multiple implants*); (4) for cumulative traumatic injuries (such as carpal tunnel and certain back injuries) the date of incident is the earlier of *the date that treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis*; or *the first date that formal diagnosis was made* by any medical practitioner.

Box 12 - Injury Description

Describe how the injury happened, the nature of the injury and the part--or parts--of the body injured.

Box 13 - Surgeries due to the alleged injury

List any surgeries you had, and the dates that you had them, as a result of the alleged injury.

Box 14 - Diagnosis or Nature of Illness or Injury ICD-9-CM Codes

If multiple body parts are affected, multiple codes may be necessary, but it is not necessary to use all eight fields. No "V Codes" or codes from an exclusion list published by CMS are permitted. You must enter at least one diagnosis code. You may also attach a 1500 Health Insurance Claim Form related to the injury in lieu of entering codes.

Box 15 - Reception of worker's compensation benefits

If you received worker's compensation benefits related to the alleged injury, list the name of the insurance carrier or self-insured employer who paid them. Also list the date that you received your last payment of benefits.

Boxes 16 - 17 - Applicant's Signature and Date Signed

Sign and date the claim form.

Who can I contact for more information regarding the WISBF Barred Claim Form?

Call or write the Wisconsin Worker's Compensation Division. Our mailing address is P.O. Box 7901, Madison, Wisconsin 53707-7901. Our telephone number is (608) 266-1340 or you can reach us by fax at (608) 267-0394.

WORK INJURY SUPPLEMENTAL BENEFIT FUND BARRED CLAIM

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Pursuant to the mandatory reporting requirements for the Department of Workforce Development, Division of Worker's Compensation, as a Responsible Reporting Entity under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 this completed claim form must be filed with an Application for Hearing for all barred traumatic or occupational injury claims made against the Work Injury Supplemental Benefit Fund. It can be mailed to the Worker's Compensation Division, P. O. Box 7901, Madison, WI 53707-7901 (or filed in person at the State Office Building, 201 East Washington Ave., Room C100, Madison, WI).

Provision of your Social Security Number (SSN) is mandatory under Section 111 of Medicare, Medicaid and SCHIP Extension Act 2007 (42 U.S.C. s. 1395y (b) (7) & (8)) and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

1. Employee Name	2. Employee Social Security Number	3. Date of Birth (mm/dd/yy)	4. Age

5. Employee Mailing Address		
6. Employee Telephone Number (include area code) ( ) -	7. Sex ☐ Male ☐ Female	8. Have You Applied For or Are You Receiving Social Security Benefits? ☐ Yes ☐ No
9. Have You Applied For or Are You Covered Under Medicare? ☐ Yes ☐ No If Yes, Medicare Claim Number:		10. Date of Injury (mm/dd/yy)
11. Date of Incident as defined by the Centers for Medicare & Medicaid Services (see the instructions for box 11) (mm/dd/yy)		
12. Description of the nature of the injury, including parts of the body affected and the cause of the injury		

13. Surgeries you had due to the alleged injury

1. Date: (mm/ddy/yy) Name of Doctor
2. Date: (mm/ddy/yy) Name of Doctor
3. Date: (mm/ddy/yy) Name of Doctor

14. Diagnosis or Nature of Illness or Injury ICD-9-CM Codes. Please see the instructions.
You may also attach a 1500 Health Insurance Claim Form related to the injury in lieu of entering codes.

1. . 2. . 3. . 4. .

5. . 6. . 7. . 8. .

15. Have you received worker's compensation benefits for this injury/disability? ☐ Yes ☐ No
Name of the worker's compensation insurance carrier or self-insured employer:
Date of last payment of benefits: (mm/dd/yy)

I declare that to the best of my knowledge and belief, the information contained in this claim form is true, correct and complete and reflects actual events that occurred.

16. Applicant Signature	17. Date Signed