

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CASE PROGRESS REPORT

☐ Initial **SA** ☐ Supplement **AN/AP** ☐ Final **FN** ☐ Reopened **AN/AP**

Board Claim No. 0005	Employee Last Name 0043, 0255	Employee First Name 0044	M.I. 0045	Social Security Number 0042	Date of Injury 0031
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A. IDENTIFYING INFORMATION

EMPLOYER	Name 0018 0016	Insurer /Self Insurer File Number 0015	SBWC ID# (five digit no.) N/A	Date of Final Weekly Payment FN/ 0195
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B. PAYMENT TYPE

Enter actual amounts paid

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
<input type="checkbox"/> (a) Temporary Total	0085/0134/050 and 250	0090	0091	0086
<input type="checkbox"/> (b) Temporary Partial	0085/0134/070	0090	0091	0086
<input type="checkbox"/> (c) Permanent Partial	0085/0134/030	0090	0091	0086
<input type="checkbox"/> (d) Death	0085/0134/010	0090	0091	0086
<input type="checkbox"/> (e) Stipulation/Settlement	0085/0222/0293 = SF,SP,AS,AW			0218
<input type="checkbox"/> (f) Advances	0085/0222/0293 = AD			0218

C. PAYMENTS

TOTAL LOST TIME PAYMENTS TO DATE

1	Total Weekly Benefits	0086 + 0218 + 0216(340)
2	Physician Benefits	0216/350
3	Hospital Benefits	0216/360
4	Pharmacy Benefits	0216/450
5	Physical Therapy	0216/460
6	Chiropractic	0216/465
7	Other (Medical)	0216/370, 455, 470, 475, 490
8	Rehabilitation / Vocational (excluding all of the above)	0216/380, 390, 400
9	Late Payment Penalties	0216/310
10	Assessed Attorney's Fees	0216/330 awarded
11	Burial	0216/300
	Totals	Total Section C

D. Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks

0002/AP [0216/430 and 0216/440] = Other (Payment from Previous Claim Admin) or Other = DN0130 = H (CSL)
0092/B = for Subrogation
0226 = 820, 830, 870, 880 ,890 = for Over Payment 0226 = 850 = for SITF

E. ☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name		Signature		Date
Address			E-mail	
City	State	Zip Code	Phone Number	
Insurer/Self Insurer Name 0007		Claims Office Name 0188		