GEORGIA

SUBSEQUENT INJURY TRUST FUND
Marquis II Tower, Suite 1250
285 Peachtree Center Ave
Atlanta, Georgia 30303-1229

REIMBURSEMENT REQUEST

FORWARD ONLY ONE REQUEST
PER 13 WEEKS OF PAID INCOME OR
MEDICAL BENEFITS
(Submit this form in duplicate)

( ) **Initial Request** ( ) **Intermediate Request** ( ) **Final Request**
(*Please check applicable box*)

_____ Social Security #

_____ Insurer #

_____ Date of Accident

_____ Compensation Rate

_____ Subsequent Injury #

_____
Insurer Name (as shown on policy) or Self-Insurer

MAIL CHECK TO:

_____

_____ Employee: _____

_____ Employer: _____

TOTAL COMPENSATION PAID Attach WC-2, WC-4 & WC 104 forms if not filed with Fund on a prior request	**Date From**	**Date Through**	**Number of Weeks ***	**Amount**
TOTAL DISABILITY				
TEMPORARY PARTIAL Attach list of weekly payments if less than maximum at any time				
PERMANENT PARTIAL _____% Member: _____				
OTHER (Specify: i.e., Death, Settlement, Advance, etc.)				
* compute partial weeks in decimals		TOTAL INDEMNITY TO DATE		
		Weeks		Amount
Less 104 weeks consisting of: Total Disability Weeks				< >
Temp Partial Weeks				
NET REIMBURSABLE INDEMNITY				
LESS ANY PRIOR INDEMNITY REIMBURSEMENT PAID THROUGH _____ date				< >
TOTAL INDEMNITY REIMBURSEMENT REQUESTED (#_____) weeks				
TOTAL MEDICAL REIMBURSEMENT REQUESTED (See Reverse Instructions)				
TOTAL REIMBURSEMENT REQUESTED				

In compliance with SITF Rule 622-1-.06(1), I hereby certify that the above payments have been made in accordance with the provisions of the Georgia Workers' Compensation Law. I further certify that appropriate investigation has been conducted to assure the accuracy of these payments. (See Reverse Side #IV)

NOTICE: Pursuant to OCGA§ 34-90-360(c) and SITF Rule 622-1-04(2)(a), the undersigned certifies that reserves on this claim have been reduced to the threshold limits of reimbursement. (THIS CERTIFICATION DOES NOT APPLY TO SELF-INSURED EMPLOYERS.)

No reimbursement will be made unless the claiming party signs this form (SITF Rule 622-1-.06(1)(c).

Signed by: _____

Title: _____

Date: _____

THIS SPACE FOR SITF PURPOSES ONLY

Audited on _____

By: _____

Date of adjustment notification_____

Approved for payment_____

If you have a disability and need assistance in completing this form, please contact the Subsequent Injury Trust Fund at (404) 656-7000; FAX (404) 656-7001.

S.I. "C" 6/12

I. REIMBURSEMENT REQUESTS

A. Reimbursement Request Forms S.I. "C" are provided free of charge. This form can also be downloaded from the SITF's Website: http://sitf.georgia.gov

B.

1. A completed Reimbursement Request form must be returned to the SITF for each request. Both indemnity and medical may be included on the same form.

2. The Reimbursement Request form **must** be accompanied by an itemized list of all medical expenses, if medical reimbursement is requested. Attach copies of all medical bills and number them in the lower right hand corner to correspond with numbers on itemized list. Use the "date incurred" to place bills in chronological order; DO NOT BATCH BY PROVIDER (except Rx).

C. The itemized list **must** be in the following format:

Provider Name	Date Incurred	Amount
1. General Hospital	1-16-96 to 1-24-96	$3,470.14
2. J.D. Hanson, M.D.	2-14-96	384.00
3. Jones Boot Store Orthopedic Boots	3-6-96	75.00
4. General Hospital	5-6-96 to 5-15-96	9,576.93

In lieu of itemized list and individual bill copies from each provider, you may forward a certified counterpart of the employer/insurer's electronically or computer-generated pay document or a fee schedule audit. (SITF Rule 622-1-.06, amended July 11, 2000.) This document must contain all of the following:

1. Payment date 2. Provider name 3. Date of provider service 4. ICD Code(s) 5. CPT code(s) 6. Billed amount 7. Amount paid (according to fee schedule)

NOTE:
Medical narratives and rehabilitation reports corresponding with medical/rehabilitation reimbursement requests must be filed with SITF before such expenses will be considered for payment (SITF Rule 622-1-.06)

Funeral benefits, administrative and legal costs **are not** reimbursable.

II. HOW TO COMPUTE MEDICAL REIMBURSEMENT

A. Reimbursement for all eligible charges incurred will be 50% of any amount over $5,000.
(Example: $7,000 less $5,000 x 50% = $1,000 Reimbursement)

B. Reimbursement for all eligible charges incurred after $10,000 medical cost will be at 100%.

III. HOW TO REQUEST REIMBURSEMENT FOR INDEMNITY

A. Total Disability:
1. Forward copies of WC-2 and WC-4 forms when requesting initial indemnity reimbursement.
2. Forward copy of subsequent WC-4 form annually thereafter and with **final** payment request.
3. Forward copies of WC-2 form on subsequent indemnity reimbursement requests where another loss-time and/or return-to-work period has occurred and which affects the request on front of this form.
4. Forward copy of WC-104 for post-7/01/92 accidents.

B. Temporary Partial Disability:
Anytime the employee received temporary partial benefits, attach a list breaking down weekly payments if such payment amounts were less than the maximum allowable under OCGA §34-9-262. The Fund reserves the right to request a copy of insurer's/insured's actual payment record.

C. The Fund will not reimburse penalty fines, attorney fees or court costs levied upon the employer/insurer resulting from non-compliance with Title 34 of the Official Code of Georgia.

IV. EXAMPLES OF COMPLIANCE WITH SITF RULE 622-1-.06.

A. Investigation to confirm that employee is entitled, or continues to be entitled to receive weekly income benefits.
B. Indemnity benefits are paid consistent with Georgia Workers' Compensation laws.
C. Investigation to confirm that medical costs are related to the accident are usual and customary charges and paid consistent with Georgia Workers' Compensation fee schedule.
D. All medical, rehabilitation and related documents are forwarded to the Fund relative to treatment in order to obtain medical reimbursement.