WC-4 CASE PROGRESS REPORT

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## CASE PROGRESS REPORT

0 Initial SA/02 | 0 Supplement AN/AP/02 | 0 Final FN/02 | 0 Reopen AN/02/RB

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

## A. IDENTIFYING INFORMATION

| | Name | Insurer /Self Insurer File Number | SBWC ID# (five digit no.) | Date of Final Weekly Payment |
|---|---|---|---|---|
| EMPLOYER | 0018 0016 | 0015 | N/A 0006 | FN/ 0195 |

| B. PAYMENT TYPE Enter actual amounts paid | RATE | WEEKS | DAYS | TOTAL PAYMENTS |
|---|---|---|---|---|
| 0 (a) Temporary Total | 0085/0134/050 | 0090 | 0091 | 0086 |
| 0 (b) Temporary Partial | 0085/0134/070 | 0090 | 0091 | 0086 |
| 0 (c) Permanent Partial | 0085/0134/030 | 0090 | 0091 | 0086 |
| 0 (d) Death | 0085/0134/010 | 0090 | 0091 | 0086 |
| 0 (e) Stipulation/Settlement | 0085/0222/0293 = SF, AW | | | 0218 |
| 0 (f) Advances | 0085/0222/0293 = AD | | | 0218 |

| | C. PAYMENTS | TOTAL LOST TIME PAYMENTS TO DATE |
|---|---|---|
| 1 | Total Weekly Benefits | 0086 + 0218 |
| 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 | 0216/340 on behalf of the injured worker |
| 11 | Burial | 0216/300 |
| | **Totals** | Total Section C |

**D. Recovery code:** 0 for Subrogation 0 for Overpayment 0 for SITF 0 Other

**Remarks**

0002/AP [ 0216/430 and 0216/440] = Other (Payment from Previous Claim Admin) or Other = DN0130 = H (CSL)
0126/M 0092/B = for Subrogation
0226 = 820, 830, 870, 880, 890 = for Over Payment 0226 = 850 for SITF

**E.** 0 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 | Claims Office Name |
|---|---|
| 0007 | 0188 |