

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION  
**DIVISION OF LABOR AND MANAGEMENT**  
 123 W. Missouri Ave. Pierre, South Dakota 57501  
 Tel: 605.773.3681 Fax: 605.773.4211 dlr.sd.gov

## MONTHLY PAYMENT REPORT

**Workers' Compensation Expenditure Report for** \_\_\_\_\_ '\_\_\_\_'  
(month) (year)

**Claim Administrator Information:**

Claim Administrator Federal ID No \_\_\_\_\_ aa \_\_\_\_\_ Carrier Code \_\_\_\_\_ Claim # \_\_\_\_\_  
 Name (DBA) \_\_\_\_\_ aa \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Form Completed By \_\_\_\_\_ aaa \_\_\_\_\_ aa \_\_\_\_\_

**Employer Information:**

Employer Federal ID No \_\_\_\_\_ Employer Name (DBA) \_\_\_\_\_

**Employee/Injury Information:**

Employee/Claimant SSN \_\_\_\_\_ aaaa \_\_\_\_\_ Date of Injury \_\_\_\_\_  
 Body Part(s) Injured \_\_\_\_\_ aa \_\_\_\_\_ aaa \_\_\_\_\_ a \_\_\_\_\_ aa \_\_\_\_\_ aa\_a \_\_\_\_\_  
 Employee/Claimant Name \_\_\_\_\_ aaaaaa \_\_\_\_\_ (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI)

**Payment Information:**

<u>DISABILITY</u>	<u>Date of Disability</u>	<u>No. of Weeks Paid</u>	<u>Amount Paid</u>
210 - Temporary Partial	_____	_____	_____
220 - Temporary Total	_____	_____	_____
230 - Permanent Partial	_____	_____	_____
240 - Permanent Total	_____	_____	_____
250 - Rehabilitation	_____	_____	_____
260 - Disability Settlement/Lump Sum	_____	_____	_____

<u>FATALITY</u>	<u>Date of Fatality:</u>	<u>No. of Weeks Paid</u>	<u>Amount Paid</u>
312 - Fatality Payments	_____	_____	_____
311 - Fatality Settlement/Lump Sum		_____	_____
313 - Transportation & Burial Expenses		_____	_____

<u>MEDICAL EXPENSES:</u>	<u>Amount Paid</u>	<u>MISCELLANEOUS EXPENSES:</u>	<u>Amount Paid</u>
102 - Chiropractor	_____	402- Interest to Claimant	_____
113 - Counseling Services	_____	404 - Deductible Reimbursement	_____
103 - Dentist	_____	112 - Investigative Fees	_____
104 - Doctor	_____	111 - Legal Fees	_____
105 - Equipment	_____	403 - Penalty Charged to Employer	_____
115 - Home Health Care	_____	114 - Rehabilitation Consultant	_____
101 - Hospital	_____	401 - Subrogation	_____
106 - Pharmacy	_____	117 - Case Management Fees	_____
110 - Physical Therapy Fees	_____	116 - Miscellaneous Expenses	_____
109 - Radiology	_____	(please specify)	
107 - Transportation	_____		
108 - Other Medical Expenses	_____		
118 - IME	_____		