

# Instructions for Completing the Final Payment Notice

Please read all pages

This form is “**fillable**”. That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the appropriate check box (field) and use the tab key to navigate to the next field. To fill in a **check box**, click inside the box with your mouse. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security #. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**FINAL PAYMENT NOTICE**

**Reason for Filing** - Whenever a worker's compensation claim has been closed by final order of the director, administrative law judge, Industrial Claim Appeals Panel, or court, the Insurer shall file a Final Payment Notice within 60 days of the date of the final order. The information on this form captures the total cost of claims for statistical reporting of trends and for reports to the legislature. This Final Payment Notice is being filed for the following reason: (check one)

☐ Full and Final Settlement ☐ Final Order ☐ *Clauses Order* ☐ Other

**“Clear Entire Form” button**  
Clears all information at once

**“Check Box”**  
Click in box

Type of Filing (check one) ☐

WC # \_\_\_\_\_ Insurer/TPA Claim # \_\_\_\_\_  
\_\_\_\_\_ Insurer Name \_\_\_\_\_  
\_\_\_\_\_ TPA Name \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Adjuster Name \_\_\_\_\_  
Date of MMI \_\_\_\_\_ Adjuster Phone \_\_\_\_\_

Total Paid \_\_\_\_\_  
☐ TTD # of Weeks Paid \_\_\_\_\_ # of Days Paid \_\_\_\_\_

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Thursday  
5/22/2003

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION  
**FINAL PAYMENT NOTICE**

**Reason for Filing** - Whenever a worker's compensation claim has been closed, the Insurer shall file a Final Payment Notice within 60 days of the date of closure. The information on this form captures the Insurer/TPA claim number, cost of claims for statistical reporting of trends, and for reports to the legislature. This Final Payment Notice is being filed for the following reason: (check one)

\_\_\_\_\_ Full and Final Settlement \_\_\_\_\_ Final Order \_\_\_\_\_ Closure Order \_\_\_\_\_ Final Admission \_\_\_\_\_ Other

**Type of Filing** (check one) \_\_\_\_\_ Original \_\_\_\_\_ Amended \_\_\_\_\_ **Date Mailed/Delivered** \_\_\_\_\_

WC # \_\_\_\_\_ Insurer/TPA Claim # \_\_\_\_\_

Claimant's Name \_\_\_\_\_ Insurer Name \_\_\_\_\_

SS # \_\_\_\_\_ TPA Name \_\_\_\_\_

Date of Injury \_\_\_\_\_ Adjuster Name \_\_\_\_\_

Date of MMI \_\_\_\_\_ Adjuster Phone \_\_\_\_\_

**Total Paid**

\_\_\_\_\_ TTD \_\_\_\_\_ # of Weeks Paid \_\_\_\_\_ # of Days Paid

\_\_\_\_\_ TPD

\_\_\_\_\_ Employer Paid (§ 8-42-124, C.R.S.)

\_\_\_\_\_ Whole Person PPD \_\_\_\_\_ %

\_\_\_\_\_ Scheduled PPD \_\_\_\_\_ % \_\_\_\_\_ Part of Body \_\_\_\_\_ % \_\_\_\_\_ Part of Body (See Part of Body Table)  
\_\_\_\_\_ % \_\_\_\_\_ Part of Body \_\_\_\_\_ % \_\_\_\_\_ Part of Body

\_\_\_\_\_ PTD

\_\_\_\_\_ Disfigurement

\_\_\_\_\_ Hospital Costs

\_\_\_\_\_ Physician Costs

\_\_\_\_\_ Other Medical Costs

\_\_\_\_\_ Settlement/Stipulation

\_\_\_\_\_ Legal Costs

\_\_\_\_\_ Interest Paid

\_\_\_\_\_ Penalties Paid

\_\_\_\_\_ Fatal Benefits

\_\_\_\_\_ Date of Death: \_\_\_\_\_

\_\_\_\_\_ Funeral Costs

\_\_\_\_\_ Vocational Rehab

\_\_\_\_\_ Maintenance (RMB)

\_\_\_\_\_ Other Rehabilitation

\_\_\_\_\_ Maintenance (VR

\_\_\_\_\_ Services)

<b>Part of Body Table</b> <b>Final Admission Body Codes Converting To Final Payment Notice (FPN) Body Codes</b>			
Colorado Part Of Body Code	Description Colorado Part Of Body Code	FPN Body Codes	Description Of Final Payment
01	Arm @ Shoulder	31	Upper Arm
03	Hand @ Wrist	34	Wrist
04	Thumb @ Metacarpal	37A	Thumb @ Metacarpal
05	Thumb @ Proximal	37B	Thumb @ Proximal Joint
06	Thumb @ Distal	37C	Thumb @ Distal Joint
07	Index @ Metacarpal	36A	Index @ Metacarpal
08	Index @ Proximal	36B	Index @ Proximal
09	Index @ Second	36C	Index @ Second Joint
10	Index @ Distal	36D	Index @ Distal Joint
11	Middle @ Metacarpal	36E	Middle @ Metacarpal
12	Middle @ Proximal	36F	Middle @ Proximal
13	Middle @ Second	36G	Middle @ Second Joint
14	Middle @ Distal	36H	Middle @ Distal Joint
15	Ring @ Metacarpal	36I	Ring @ Metacarpal
16	Ring @ Proximal	36J	Ring @ Proximal
17	Ring @ Second	36K	Ring @ Second Joint
18	Ring @ Distal	36L	Ring @ Distal Joint
19	Little @ Metacarpal	36M	Little @ Metacarpal
20	Little @ Proximal	36N	Little @ Proximal Joint
21	Little @ Second	36O	Little @ Second Joint
22	Little @ Distal	36P	Little @ Distal Joint
23	Leg @ Hip	52	Upper Leg
25	Leg @ Foot, Heel, Ankle	56	Foot
26	Great Toe @ Metatarsal	58A	Great Toe @ Metatarsal
27	Great Toe @ Proximal	58B	Great Toe @ Proximal
28	Great Toe @ Distal	58C	Great Toe @ Distal Joint
29	Other Toe @ Metatarsal	57C	Other Toe @ Metatarsal
30	Other Toe @ Proximal	57D	Other Toe @ Proximal
31	Other Toe @ Distal	57G	Other Toe @ Distal Joint
32	Eye Enucleation	14A	Eye Enucleation
33	Blindness One Eye	14B	Total Blindness One Eye
34	Deafness Both Ears	13A	Total Deafness Both Ears
35	Deafness One Ear	13B	Total Deafness One Ear
36	Total Hearing 2nd Ear	13C	Total Hearing 2nd Ear

## INSTRUCTIONS/DEFINITIONS

Report the full amount paid by benefit type. Report cumulative costs on any subsequent Final Payment Notices filed for the same claim.

<b><u>Reason for Filing</u></b>	Check the appropriate category reflecting the reason for filing. If Other, please specify.
<b><u>Type of Filing</u></b>	Check <b>Original</b> if this is the first Final Payment Notice filed by this party on this claim. A Final Payment Notice is required to be filed 60 days after closure of a claim. Check <b>Amended</b> if the Original Final Payment Notice was filed in error <b>or</b> if additional benefits were paid after the original filing. Report cumulative totals on all amended Final Payment Notices.
<b><u>Date Mailed</u></b>	Date Final Payment Notice was mailed or delivered to the Division.
<b><u>Claim Demographics</u></b>	
<b>WC #</b>	Number assigned by the Division to identify the specific claim. If the Settlement involves multiple claims, report the settlement amount on only one claim. Report amounts paid on the other claims (where any benefits were paid) on a separate Final Payment Notice for each claim.
<b>Claimant's Name</b>	Injured worker's legally recognized full name.
<b>SS #</b>	Number assigned by the Social Security Administration to identify the employee.
<b>Date of Injury</b>	Date of the accident or date of notice of an occupational disease or exposure.
<b>Date of MMI</b>	Date of maximum medical improvement (MMI) after which further recovery from or improvement to an injury or disease can no longer be anticipated based on reasonable medical probability.
<b>Insurer/TPA Claim #</b>	Number assigned by the Insurer or Third Party Administrator to identify the specific claim.
<b>Insurer Name</b>	Name of the insurer or self-insured employer assuming financial responsibility for the claim.
<b>TPA Name</b>	Name of the Third Party Administrator contracted to adjust the claim, if applicable.
<b>Adjuster Name</b>	Name of the person administering the claim.
<b>Adjuster Phone</b>	Telephone number of the adjuster.
<b><u>Total Paid</u></b>	<b>List actual amounts paid prior to this filing.</b>
<b>TTD</b>	Temporary Total Disability (TTD) benefits paid for the period claimant was unable to earn any wages and not reported as Employer Paid benefits (§ 8-42-124).
<b># of Weeks Paid</b>	Number of whole weeks paid for the listed TTD benefits.
<b># of Days Paid</b>	Number of days paid for the listed TTD benefits, not included in the number of weeks paid.
<b>TPD</b>	Temporary Partial Disability (TPD) benefits paid for the period during which the claimant was unable to earn full wages and not reported as Employer Paid benefits (§ 8-42-124).
<b>Employer Paid</b>	Lost-time benefits reimbursed to the employer pursuant to § 8-42-124 and not reported as TTD or TPD benefits in the above categories.
<b>Whole Person PPD</b>	Permanent Partial Disability (PPD) benefits paid for permanent medical impairment not listed on the schedule. List only actual amounts paid.
<b>Whole Person %</b>	Permanent impairment rating for impairment not listed on the schedule.
<b>Scheduled PPD</b>	Permanent Partial Disability (PPD) benefits paid per the statutory schedule at § 8-42-107(2). List only actual amounts paid.
<b>Scheduled Injury %</b>	Permanent impairment rating for impairment to the scheduled part of body.
<b>Part of Body</b>	The code corresponding to the part of body for the scheduled injury impairment rating. See Part of Body Table on the front of the form. Use the code in the first column of the Table.
<b>PTD</b>	Permanent Total Disability (PTD) benefits paid for medical impairment and other factors that render the claimant unable to earn any wages.
<b>Disfigurement</b>	Benefits paid for permanent scarring.
<b>Hospital Costs</b>	Total paid to hospitals for services for this claim.
<b>Physician Costs</b>	Total paid to physicians for services for this claim.
<b>Other Medical Costs</b>	Total paid for medical services not otherwise reported for this claim.
<b>Settlement/Stipulation</b>	Settled amounts over and above other amounts paid and not reported elsewhere on this form. Report cumulative costs on any subsequent Final Payment Notices filed for the same claim.
<b>Legal Costs</b>	Total respondents' legal expenses paid for this claim.
<b>Interest Paid</b>	Total interest paid for this claim.
<b>Penalties Paid</b>	Total penalties paid for this claim.
<b>Fatal Benefits</b>	Compensation benefits paid for death resulting from a work-related accident or occupational disease.
<b>Date of Death</b>	On a fatal claim, the date the injured worker died.
<b>Funeral Costs</b>	Total funeral expenses paid for this claim.
<b>Vocational Rehabilitation Maintenance</b>	Total weekly maintenance benefits paid while the claimant participated in a vocational rehabilitation program.
<b>Other Rehabilitation Maintenance</b>	Total paid vocational rehabilitation evaluation and education services plus other vocational services not otherwise reported for this claim.
<b><u>Insurer Identifying Information</u></b>	
<b>Block #</b>	Three-digit Division assigned number identifying the insurer or self-insured employer listed above.
<b>Adj. Code</b>	Two-alpha character Division assigned code identifying the TPA listed above.