

**South Dakota Department of Labor
Division of Labor and Management**

MONTHLY PAYMENT REPORT

Employee: _____ Social Security No: _____

Employer: _____ Date of Injury: _____

Insurer: _____ Insurance Claim No: _____

Address: _____ Telephone No: _____

City, State, Zip: _____ Report for Month/Year of: _____

	<u>No. of Weeks Paid</u>	<u>Amount Paid</u>
<u>DISABILITY:</u>		
210 Temporary Partial	_____	_____
220 Temporary Total	_____	_____
230 Permanent Partial	_____	_____
240 Permanent Total	_____	_____
250 Rehabilitation	_____	_____
260 Settlement/Lump Sum	_____	_____
<u>FATALITY:</u>		
312 Fatality Payments	_____	_____
311 Fatality Settlement/Lump Sum	_____	_____
<u>MEDICAL EXPENSES:</u>		
102 Chiropractor	_____	_____
113 Counseling Services	_____	_____
103 Dentist	_____	_____
104 Doctor	_____	_____
105 Equipment	_____	_____
115 Home Health Care	_____	_____
101 Hospital	_____	_____
106 Pharmacy	_____	_____
110 Physical Therapy Fees	_____	_____
109 Radiology	_____	_____
107 Transportation	_____	_____
108 Other Medical Expenses (please specify)	_____	_____
<u>MISCELLANEOUS EXPENSES:</u>		
402 Interest to Claimant	_____	_____
112 Investigative Fees	_____	_____
111 Legal Fees	_____	_____
403 Penalty Charged to Employer	_____	_____
114 Rehabilitation Consultant	_____	_____
401 Subrogation	_____	_____
116 Miscellaneous Expenses (please specify)	_____	_____

Form Completed By: _____

Submit form to: South Dakota Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, SD 57501-2291
Telephone (605)773-3681