pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF ADJUDICATION

PENNSYLVANIA WC HEARING - INTERESTED PARTY UPDATE REQUEST

Directions: This form is to be used by counsel when there is a discrepancy between the Interested Parties table in WCAIS and the parties that counsel has for a given matter. Prior to the first hearing on the matter, **complete this form *only* for the parties that are incorrect. Enter the correct information exactly as it should appear.** Upload the form as a Letter to the Judge on the Documents & Correspondence tab of the Dispute Summary. This form is not to be used for making updates to attorney profile information in WCAIS.

* = required field

Date* ____________ **WCAIS Claim/DSP/A #*** ____________

Attorney*

Name*: ____________________
First MI Last

Representing*: ____________________
Claimant, insurer or employer

PA Bar ID*: ____________________

ALL FIELDS ABOVE THIS LINE ARE REQUIRED

Claimant

Name: ____________________
First MI Last

Address: ____________________
Street Address City State ZIP+4

SSN*: ____________________ (required for update)

Employer

Name: ____________________ Self-Insured ☐

Address: ____________________
Street Address City State ZIP+4

FEIN*: ____________________ (required for update)

Insurer

Name: ____________________

Address: ____________________
Street Address City State ZIP+4

FEIN*: ____________________ (required for update)

TPA

Name: ____________________

Address: ____________________
Street Address City State ZIP+4

FEIN*: ____________________ (required for update)

Healthcare Provider and Healthcare Professional updates may be made on the second page of this form

Pennsylvania WC Hearing - Interested Party Update Request

Health Care Provider (Organizations, e.g., Hospital)

Name: ____________________

Address: ____________________

Street Address City State ZIP+4

FEIN*: ____________________ (required for update)

Health Care Professional (Persons, e.g., Doctor)

Name: ____________________

Facility (Provider): ____________________

Address: ____________________

Street Address City State ZIP+4

Professional License #*: ____________________ (required for update)

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program