

## ANSWER TO PETITION TO/FOR:

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

-   -

DATE OF INJURY

-   -

MM DD YYYY

WCAIS CLAIM NUMBER

### EMPLOYEE

First name \_\_\_\_\_

Last name \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_

Telephone \_\_\_\_\_

### EMPLOYER

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_

Telephone \_\_\_\_\_ FEIN \_\_\_\_\_

### VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_

Telephone \_\_\_\_\_ FEIN \_\_\_\_\_

NAIC code \_\_\_\_\_ or Insurer code \_\_\_\_\_

Insurer/TPA claim # \_\_\_\_\_

### INJURY INFORMATION

Provide the following information if Employer has accepted liability for this injury:

Part of body injured \_\_\_\_\_

Nature of injury \_\_\_\_\_

Accident/injury description narrative \_\_\_\_\_

Check if occupational disease

### TO YOUR HONORABLE JUDGE:

In answer to the following petition(s):

- |  |  |
|--|--|
| <input type="checkbox"/> Review medical treatment and/or billing | <input type="checkbox"/> Terminate compensation benefits |
| <input type="checkbox"/> Modify compensation benefits            | <input type="checkbox"/> Suspend compensation benefits   |
| <input type="checkbox"/> Review compensation benefits            | <input type="checkbox"/> Reinstate compensation benefits |
| <input type="checkbox"/> Set aside final receipt                 | <input type="checkbox"/> Penalties                       |
| <input type="checkbox"/> Joinder of additional defendant         |  |

In the above case, the respondent respectfully pleads as follows: (Answer in numerical order in response to corresponding numbers on petitions.)

