

## PETITION TO/FOR: (Check any that apply)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER  
 -  -

DATE OF INJURY  
 -  -   
 MM DD YYYY

WCAIS CLAIM NUMBER

- Modify compensation benefits  
(Reduce/increase amount of workers' compensation)
- Penalties (For violation of the act, rules and regulations)
- Reinstate compensation benefits
- Review compensation benefits
- Review compensation benefits offset
- Review medical treatment and/or billing

- Seek approval of a compromise and release agreement  
(Ask judge to approve settlement)
- Set aside final receipt  
(Ask judge to set aside agreement to stop compensation)
- Suspend compensation benefits
- Terminate compensation: Based upon physician's affidavit,  
a special supersedeas hearing to be scheduled
- Terminate compensation benefits  
(Employee fully recovered without any disability)

This petition is filed on behalf of:  Employee  Employer/Insurer

### EMPLOYEE

First name \_\_\_\_\_  
 Last name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 If deceased - Dependent/Guardian/Personal Representative  
 First name \_\_\_\_\_  
 Last name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 County \_\_\_\_\_ Telephone \_\_\_\_\_

### EMPLOYER

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 County \_\_\_\_\_  
 Telephone \_\_\_\_\_ FEIN \_\_\_\_\_

### VS. INSURER, FUND 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

**"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND, SUBSEQUENT INJURY FUND, SELF-INSURANCE GUARANTY FUND OR PRE-SELF-INSURANCE GUARANTY FUND.**

TO YOUR HONORABLE JUDGE:

The above petitioner requests the workers' compensation judge to order the above action as of  -  -   
 for the following reason(s).  
 MM DD YYYY

- 1. Full recovery
- 2. Specific job offered
- 3. Work generally available
- 4. Able to return to unrestricted work
- 5. Has returned to work
- 6. Reasonable treatment refused
- 7. Resolution to specific loss
- 8. Incorrect description of injury
- 9. Incorrect average weekly wage
- 10. Medical bills unpaid
- 11. Medical bills not related
- 12. Worsening of condition
- 13. Injury causing decreased earning power
- 14. Section 314 order violated
- 15. Voluntary withdrawal from workforce
- 16. Violation of the act, rules and regulations
- 17. Subrogation, credit or offset for
  - UC  Social Security  Third party recovery
  - S&A  Pension

18. Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Compensation benefits

- being paid
- have been paid based on a:

Notice of compensation payable dated  -  -

Judge's order dated  -  -

Agreement dated  -  -

Board order dated  -  -

Supplemental agreement dated  -  -

Court order dated  -  -

This is an Act 46 (firefighter cancer) claim

Is supersedeas being requested pursuant to Section 413(A.2)?  Yes  No  
If yes, list reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Average weekly wage \$  .

Applicable weekly total disability rate \$  .

Date of most recent payment  -  -  Amount \$  .

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name \_\_\_\_\_  
PA attorney ID number \_\_\_\_\_  
Firm name \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Telephone \_\_\_\_\_

COUNSEL FOR RESPONDENT (if known):

Attorney's name \_\_\_\_\_  
PA attorney ID number \_\_\_\_\_  
Firm name \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Telephone \_\_\_\_\_

\_\_\_\_\_  
Petitioner or Representative's signature

Date of petition  
 -  -

\_\_\_\_\_  
Petitioner or Representative's name (typed/printed)

**Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and to the attorneys of all other parties, if the attorneys are known. A proof-of-service must be attached. A proof-of-service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.**

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

**Employer Information Services**  
717.772.3702

**Claims Information Services**  
toll-free inside PA: 800.482.2383  
local & outside PA: 717.772.4447

**Hearing Impaired**  
toll-free inside PA TTY: 800.362.4228  
local & outside PA TTY: 717.772.4991

**Email**  
ra-li-bwc-helpline@pa.gov



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