pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF WORKERS' COMPENSATION DENIAL

DATE OF NOTICE
MM - DD - YYYY

DATE OF INJURY
MM - DD - YYYY

SOCIAL SECURITY NUMBER

WID NUMBER

WCAIS CLAIM NUMBER

EMPLOYEE

Date of birth MM - DD - YYYY

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ Insurer code _____

Insurer/Administrator claim # _____

TPA

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Insurer/Administrator claim # _____

ALLEGED INJURY INFORMATION

Part of body injured

Nature of injury

Accident/injury description narrative

County _____

Check if occupational disease ☐

NOTICE TO EMPLOYEE: The employer/insurer has decided to deny you workers' compensation benefits. You have the right to contest this denial by timely filing a petition. Petitions may be either electronically filed in WCAIS or sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St., Suite 202, Harrisburg, PA 17102-1400.

Do not use this form to accept a medical-only claim. This notice shall be sent to the employee or dependent and filed with the Bureau of Workers' Compensation via electronic format no later than 21 days after notice or knowledge to the employer of the employee's disability or death. A separate paper copy of this EDI-generated form should not be uploaded or sent to the Bureau.

Specific information regarding this claim is on the reverse side of this form.

(OVER)

Date the employer received notice or knew of alleged injury or date of employee's claimed disability: ☐☐ - ☐☐ - ☐☐☐☐
This date must be completed. MM DD YYYY

The employer/insurer declines to pay workers' compensation benefits to claimant because:

☐ 1. The employee did not suffer a work-related injury. The definition of injury also includes aggravation of a pre-existing condition or disease contracted as a result of employment.

☐ 2. The injury was not within the scope of employment.

☐ 3. The employee was not employed by the defendant.

☐ 4. The employee did not give notice of his/her injury or disease to the employer within 120 days within the meaning of Sections 311-313 of the Workers' Compensation Act.

☐ 5. Other good cause; please explain fully in the space below.

Claims representative's name _____ Telephone _____

EMPLOYEES' RIGHTS TO CONTEST DENIAL

You have the right to contest this denial of your claim for workers' compensation benefits. Your petition will be heard by a workers' compensation judge. You and your employer will have the opportunity to testify and provide medical evidence with respect to your claim. Both you and your employer will have the right to bring witnesses. You may retain an attorney to represent you in this proceeding although representation by an attorney is not required by law. Because of the legal complications that can arise in occupational disease and workers' compensation cases, you may want to consider legal advice. **If you do not know how to contact an attorney, please contact your local Bar Association or the Pennsylvania Bar Association at 800-692-7375 for guidance in obtaining an attorney.**

The procedure for filing a petition is as follows:

1. To file a petition you may access WCAIS from www.wcais.pa.gov, or upon request a petition, Form LIBC-362, will be mailed to you. You or your attorney may file your petition online, complete and return the original petition to the Workers' Compensation Office of Adjudication by electronically attaching the document to a claim in WCAIS or by mail to the the Workers' Compensation Office of Adjudication, 1010 N. Seventh St., Suite 202, Harrisburg, PA 17102-1400.

2. A petition for an injury must be filed within three years of the date of injury. Filings for occupational disease claims, disability, or death must occur within 300 weeks from last exposure. A petition must be filed no later than three years from that date. Failure to file a petition within these rules may result in a loss of your claim.

3. You must give notice of your work-related injury or disease to your employer within 120 days of the date you knew (or should have known) that you were injured or had contracted a work-related disease.

4. When your petition is filed with the Workers' Compensation Office of Adjudication, it will be assigned to a judge for a hearing. You will be notified of your hearing date. All parties are requested to be fully prepared prior to the first hearing.

If you need petition forms or have questions, please go to www.wcais.pa.gov or contact one of the Information Services numbers listed below.

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
PA Relay 7-1-1

To view your claim file, log on to www.wcais.pa.gov

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