

NOTICE OF CHANGE OF WORKERS' COMPENSATION DISABILITY STATUS

You must submit an EDI transaction to update the status of a claim in WCAIS.

DATE OF THIS NOTICE:

MM	-	DD	-	YYYY
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EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

XXXXXX	-	XX	-	XXXXXXXXXX
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DATE OF INJURY:

MM	-	DD	-	YYYY
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WCAIS CLAIM NUMBER

XXXXXXXXXX

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 _____

ATTORNEY FOR EMPLOYEE (if known)

Name	_____
Firm name	_____
Address	_____
Address	_____
City/Town	_____ State ____ ZIP _____
Telephone	_____ PA Attorney ID number _____

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 #	_____

ATTORNEY FOR INSURER/EMPLOYER (if known)

Name	_____
Firm name	_____
Address	_____
Address	_____
City/Town	_____ State ____ ZIP _____
Telephone	_____ PA Attorney ID number _____

INSTRUCTIONS

This form must be completed, mailed to the employee and uploaded to WCAIS or mailed to the Bureau of Workers' Compensation under the provisions of the Workers' Compensation Act.

Bureau of Workers' Compensation
651 Boas Street, 8th Floor
Harrisburg, PA 17121-0750

SEE IMPORTANT INFORMATION ON THE REVERSE

As a result of an impairment rating evaluation (examination), your disability status has changed.

A change in disability status does not affect the amount of money you receive in your workers' compensation check. Partial disability status does, however, have a maximum period of 500 weeks of benefits.

The specifics of this change are listed as follows:

Date of injury: - -
MM DD YYYY

Date you reached a total of 104 weeks of total disability: - -
MM DD YYYY

Date initially established for the examination: - -
MM DD YYYY

Actual date of the rating examination: - -
MM DD YYYY

Impairment examining physician: _____

Impairment rating percentage: _____ percent

This rating evaluation was conducted in accordance with Section 306(a.3) of the Pennsylvania Workers' Compensation Act.

The above referenced Impairment Rating percentage has been used by your insurance carrier/employer to change your workers' compensation status from total disability to partial disability status.

The effective date of this status change is: - - . This effective date will be recorded on your claim record 60 days following the date of this notice.
MM DD YYYY

INSURER/EMPLOYER REPRESENTATIVE

First name _____
Last name _____
Signature _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____
Bureau Code _____

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

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

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