

## 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 NOTICE

MM	DD	YYYY							

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

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DATE OF INJURY

MM	DD	YYYY					

WCAIS CLAIM NUMBER

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### 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 _____

### 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 EMPLOYEE (if known)

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

### CLAIMS REPRESENTATIVE

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____ FEIN _____

### ATTORNEY FOR INSURER/EMPLOYER (if known)

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

## SEE IMPORTANT INFORMATION ON THE REVERSE

This notice should be clearly completed (preferably typed) and original mailed to the bureau at the address on the back of this sheet. A copy must be sent to the employee and the employee's counsel (if known).

(OVER)

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:

Claimant name: \_\_\_\_\_

Social Security number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

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.

Commonwealth of Pennsylvania  
Department of Labor & Industry  
Bureau of Workers' Compensation  
1171 S. Cameron Street, Room 103  
Harrisburg, PA 17104-2501

**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*