pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

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

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER
XXX - XX - ____ ____

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 _____

ATTORNEY FOR EMPLOYEE (if known)

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

ATTORNEY FOR INSURER/EMPLOYER (if known)

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

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 # _____

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: ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY). This effective date will be recorded on your claim record 60 days following the date of this notice.

INSURER/EMPLOYER REPRESENTATIVE

First name _____

Last name _____

Signature _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____

Bureau Code _____

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