



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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**EMPLOYER**

First name \_\_\_\_\_

Last name \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_

Telephone \_\_\_\_\_

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 \_\_\_\_\_

**ATTORNEY FOR INSURER/EMPLOYER (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 _____

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Description of compensable injury:

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This is an Act 46 (firefighter cancer) claim ☐

The referenced Insurer/Employer requests the Bureau of Workers' Compensation to select a physician for an Impairment Evaluation to be conducted with Section 306(a.3) of the Workers' Compensation Act.

Copies of this request have been served on all parties.

\_\_\_\_\_  
Claims Representative's signature

Date of this notice  
□□ - □□ - □□□□  
MM DD YYYY

\_\_\_\_\_  
Claims Representative's name (typed/printed)

\_\_\_\_\_  
Telephone

Mail to:  
651 Boas Street, 8th Floor  
Harrisburg, PA 17121

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