pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF WORKERS' COMPENSATION DENIAL

DATE OF NOTICE
__ __ - __ __ - __ __ __ __
MM DD YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER
__ __ __ - __ __ - __ __ __ __ _____

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 _____

EMPLOYER

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

ALLEGED INJURY INFORMATION

Part of body injured _____
Nature of injury _____
Accident/injury description narrative

Check if occupational disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
Contact _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

NOTICE: The employer/insurer has decided to deny you workers' compensation benefits. You have the right to contest this denial by timely filing a petition with the bureau. 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 denial shall be sent to the employee or dependent and filed with the bureau by electronic batch upload in WCAIS, by electronically attaching the document to a claim in WCAIS or by mail no later than 21 days after notice or knowledge to the employer of the employee's disability or death.

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 has not suffered a loss of wages as a result of an already accepted injury.
☐ 5. 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.
☐ 6. Other good cause. Please explain fully in the space below.

See Reverse Side For Employees' Rights To Contest Denial

Claims representative's name (typed/printed) _____ Telephone _____

_____
Claims representative's signature

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 log onto the WCAIS system at www.dli.state.pa.us/WCAIS, or upon request, a petition, Form LIBC-362, will be mailed to you. You or your attorney must 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 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. 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 received by the Workers' Compensation, Office of Adjudication, it will be assigned to a judge for 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 contact the Workers' Compensation, Office of Adjudication.

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	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

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