COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF ADJUDICATION - PETITIONS SECTION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY 800-362-4228

ANSWER TO PETITION TO/FOR:

Social Security Number: _____ - _____ - _____

Date of Injury _____ /_____ /_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

EMPLOYEE

First Name _____ Last Name _____

Address _____

Address _____

City/Town _____ State _____ Zip Code _____-_____

County _____ Telephone (_____) _____-_____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State _____ Zip Code _____-_____

County _____

Telephone (_____) _____-_____ FEIN _____

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self insured)

Name _____

Address _____

Address _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ Bureau Code _____

County _____

Claim Number _____ FEIN _____

TO YOUR HONORABLE JUDGE:

In answer to the following petition(s):

- ☐ Review Medical Treatment and/or Billing
- ☐ Modify Compensation Benefits
- ☐ Review Compensation Benefits
- ☐ Set Aside Final Receipt
- ☐ Joinder of Additional Defendant
- ☐ Terminate Compensation Benefits
- ☐ Suspend Compensation Benefits
- ☐ Reinstate Compensation Benefits
- ☐ Penalties

In the above case, the Respondent respectfully pleads as follows: (Answer in numerical order in response to corresponding numbers on petition.)

_____

_____

_____

_____

_____

_____

_____

NOTICE: This answer should be clearly completed (preferably typed) and original mailed directly to the office of the Judge to whom the case is assigned. Answers must be filed within 20 days. Every fact alleged in the petition not specifically denied by this answer shall be deemed to be admitted.

377 1011

Compensation Presently Payable Under:

- ☐ Notice of Compensation Payable
- ☐ Agreement
- ☐ Supplemental Agreement
- ☐ Award

(I) (we) submit the following facts for your consideration:

(I) (we) further submit for your consideration the following additional facts:

For the above reasons, (I) (we) request that

your Honorable Judge _____ the said petition in the captioned case.

Respondent

First Name _____ Last Name _____

Signature _____

Date: _____/_____/_____
MM DD YYYY

Attorney

Signature _____

Date: _____/_____/_____
MM DD YYYY

PLEASE ENTER MY APPEARANCE FOR RESPONDENT:
Attorney

First Name _____ Last Name _____

Firm Name _____

Address _____

Address _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ PA Attorney ID Number _____

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77P.S.§1039.2, and may also be subject to criminal and civil penalties under 18 Pa.C.S.A§4117 (relating to insurance fraud).

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