pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION TO/FOR: (Check any that apply)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

- ☐ Modify compensation benefits (Reduce/increase amount of workers' compensation)
- ☐ Penalties (For violation of the act, rules and regulations)
- ☐ Reinstate compensation benefits
- ☐ Review compensation benefits
- ☐ Review compensation benefits offset
- ☐ Review medical treatment and/or billing
- ☐ Seek approval of a compromise and release agreement (Ask judge to approve settlement)
- ☐ Set aside final receipt (Ask judge to set aside agreement to stop compensation)
- ☐ Suspend compensation benefits
- ☐ Terminate compensation: Based upon physician's affidavit, a special supersedeas hearing to be scheduled
- ☐ Terminate compensation benefits (Employee fully recovered without any disability)

This petition is filed on behalf of: ☐ Employee ☐ Employer/Insurer

EMPLOYEE

First name _____

Last name _____

Date of birth _____

If deceased - Dependent/Guardian/Personal Representative
First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

VS. INSURER, FUND 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 # _____

"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND, SUBSEQUENT INJURY FUND, SELF-INSURANCE GUARANTY FUND OR PRE-SELF-INSURANCE GUARANTY FUND.

INJURY INFORMATION

Provide the following information if Employer has accepted liability for this injury:

Part of body injured _____

Nature of injury _____

_____

_____

Accident/injury description narrative _____

_____

_____

Check if occupational disease ☐

TO YOUR HONORABLE JUDGE:

The above petitioner requests the workers' compensation judge to order the above action as of ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) for the following reason(s).

- ☐ 1. Full recovery
- ☐ 2. Specific job offered
- ☐ 3. Work generally available
- ☐ 4. Able to return to unrestricted work
- ☐ 5. Has returned to work
- ☐ 6. Reasonable treatment refused
- ☐ 7. Resolution to specific loss
- ☐ 8. Incorrect description of injury
- ☐ 9. Incorrect average weekly wage
- ☐ 10. Medical bills unpaid
- ☐ 11. Medical bills not related
- ☐ 12. Worsening of condition
- ☐ 13. Injury causing decreased earning power
- ☐ 14. Section 314 order violated
- ☐ 15. Voluntary withdrawal from workforce
- ☐ 16. Violation of the act, rules and regulations
- ☐ 17. Subrogation, credit or offset for
  - ☐ UC ☐ Social Security ☐ Third party recovery
  - ☐ S&A ☐ Pension

18. Other _____

_____

_____

Compensation benefits

☐ being paid

☐ have been paid based on a:

☐ Notice of compensation payable dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Agreement dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Supplemental agreement dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Judge's order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Board order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Court order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

This is an Act 46 (firefighter cancer) claim ☐

Is supersedeas being requested pursuant to Section 413(A.2)? ☐ Yes ☐ No
If yes, list reasons: _____

_____

_____

_____

Average weekly wage $ ☐☐☐☐☐☐ . ☐☐

Applicable weekly total disability rate $ ☐☐☐☐☐☐ . ☐☐

Date of most recent payment ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) Amount $ ☐☐☐☐☐☐ . ☐☐

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____
PA attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State _____ ZIP _____
Telephone _____

COUNSEL FOR RESPONDENT (if known):

Attorney's name _____
PA attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State _____ ZIP _____
Telephone _____

_____
Petitioner or Representative's signature

Date of petition ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

_____
Petitioner or Representative's name (typed/printed)

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and to the attorneys of all other parties, if the attorneys are known. A proof-of-service must be attached. A proof-of-service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.

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