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

ANSWER TO PETITION TO/FOR:

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 _____

VS. 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 # _____

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:

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 petitions.)

Compensation presently payable under: ☐ Notice of compensation payable ☐ Agreement

☐ Supplemental agreement ☐ Award

Additional information:

WHEREFORE, the respondent requests that the petition be dismissed or in the alternative disallowed.

Notice: This answer must be filled out as fully as possible. If not filing electronically, the original must be sent to the office of the Judge to whom the case is assigned. You must send a copy to all unrepresented parties, and to the attorney of record for all other parties which are represented by counsel. 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. Answers must be filed within 20 days of the assignment of the petition. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

PLEASE ENTER MY APPEARANCE FOR RESPONDENT:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Date filed

MM - DD - YYYY

Attorney's signature

Attorney's name (typed/printed)

Respondent's signature

Respondent's name (typed/printed)

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