pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTIFICATION OF SUSPENSION OR MODIFICATION PURSUANT TO §§ 413 (c) & (d)

DATE OF NOTIFICATION
MM - DD - YYYY

DATE OF INJURY
MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID 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 _____

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 # _____

INSTRUCTIONS

This form must be completed, mailed to the employee, and uploaded to WCAIS or mailed to the Bureau of Workers' Compensation within seven days of the suspension or modification of benefits under the provisions of the Workers' Compensation Act. You must submit an EDI transaction to match the LIBC-751 to update the status of the claim in WCAIS.

Bureau of Workers' Compensation, 651 Boas Street, 8th Floor
Harrisburg, PA 17121-0750.

You are notified that because you returned to work on MM - DD - YYYY, your weekly disability benefits for this injury have been:

☐ Suspended effective MM - DD - YYYY because you have returned to work at earnings equal to or greater than your time-of-injury earnings of $_____.

OR

☐ Modified to the rate of $_____ per week, effective MM - DD - YYYY because you returned to work at earnings less than your time-of-injury earnings.

☐ I confirm I have served a copy of this form to the Bureau of Workers' Compensation.

☐ I confirm I have served a copy of this form to the employee.

_____
Claims representative's signature

_____
Claims representative's name (typed/printed)

_____
Phone number

INSURER'S VERIFICATION

I verify that this information is true and correct based upon my knowledge, information, and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsifications to authorities. 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 and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

NOTE TO EMPLOYEE: If you do not agree with this action and wish to challenge it, please read the instructions under EMPLOYEE CHALLENGE on the back of this form.

Weekly wages must be computed in accordance with the Pennsylvania Workers' Compensation Act.

CALCULATION for partial compensation rate (to be completed for modification). The employee's new partial compensation rate is based on the claimant's present weekly earnings and is calculated as follows:

Calculation:	_____	Average weekly wage at time of injury
minus:	_____	Present weekly earnings
	_____	Subtotal
x 2/3 =	_____	New partial compensation rate (Subject to the maximum benefit)

EMPLOYEE CHALLENGE:

If you do not agree with this action, you must challenge it within (20) days of the date you receive this notice. You may challenge it online at www.WCAIS.pa.gov. Select the "File a WCOA Petition" Quick Link, "Associate" the claim number, and select "Employee Challenge Petition (LIBC-751)." Alternatively, you may challenge it by checking the box below, signing this form and mailing it to the Pennsylvania Department of Labor & Industry, Workers' Compensation Office of Adjudication (WCOA), 1010 N 7th Street, Suite 202, Harrisburg, PA 17102-1400.

If you do not challenge this action within (20) days of the date you receive this notice, you will be deemed to have admitted that you agree with the action taken on this form. In that case, this notice will have the same binding effect as a fully executed Supplemental Agreement for the suspension or modification of benefits.

☐ I do not agree with the action taken by my employer. I request a special supersedeas hearing (a hearing on whether my workers' compensation benefits can be reduced or stopped) before a Workers' Compensation Judge. A hearing is requested to be conducted in accordance with Sections 413 (c) & (d) of the Pennsylvania Workers' Compensation Act.

(if the employee has legal counsel, complete below.)

Attorney's name _____

PA attorney ID# _____

Name of firm _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

Telephone _____

Employee's signature _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

County _____

Telephone _____

(Employee to complete if different from information provided by employer)

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	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

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