How to file a lien

Filing a notice and request for allowance of lien is how you make a claim for payment of money you're owed in a workers' compensation case.

Attached is a lien form. Complete the form. Be sure to sign and date it. This form can also be completed at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm6.pdf.

Attach a full statement or itemized bill supporting the lien.

A Workers' Compensation Appeals Board (WCAB) case number must be entered in the top right hand corner of the lien. If there is no WCAB case number, contact the local Information & Assistance (I&A) office.

Send copies to your local WCAB office and to all the parties.

Submit the following documents with your form filing in the order shown:

- ✓ Document Cover Sheet
- ✓ Document Separator Sheet (*for Notice and Request for Allowance Of Lien)*
- ✓ Notice and Request for Allowance Of Lien
- ✓ Document Separator Sheet (*for Proof of Service By Mail)*
- ✓ Proof of Service By Mail

There are also time limitations for medical providers and medical-legal lien claimants to file liens. Such liens must be filed:

1. Within six months of a final decision, findings, award or order, including an order approving a compromise and release

2. Within five years of the date of injury

3. Or within one year of the date the services were provided, whichever is later. The employee's consent to allowance of lien and signature are not required.

Keep originals for your record.

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in

block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

If you do not have the name and address of your insurance company to complete a form, please link to http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N. PacifiCenter Drive, Suite 202
Information & Assistance Unit (**714) 414-7401**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit (**661) 395-2514**

EUREKA, 95501-0481
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Mall, Suite 4078
Information & Assistance Unit **(559) 445-5355**

GOLETA, 93117-5551
6755 Hollister Avenue, Suite 100
Information & Assistance Unit (**805) 968-4158**

LONG BEACH, 90802-4304
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 West 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, CA 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N. Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-2653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96001-2740
2115 Civic Center Drive, Suite 15
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit (**951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle Suite 300
Information & Assistance Unit (**916) 928-3158**

SALINAS, 93906-2204
1880 North Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 West Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7002
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

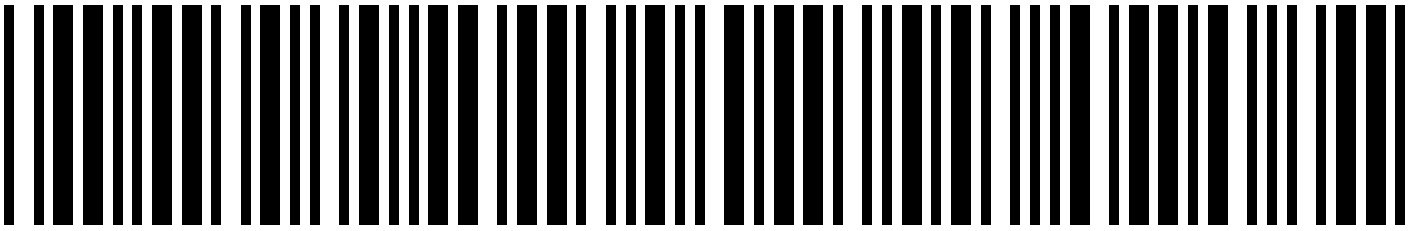
SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit (**707) 576-2452**

STOCKTON, 95202-2314
31 East Channel Street, Suite 344
Information & Assistance Unit (**209) 948-7980**

VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

DOCUMENT SEPARATOR SHEET

SAMPLE



Product Delivery Unit: ADJ

Document Type: LIENS AND BILLS

Document Title: NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

SAMPLE

Date Of Original Lien: _____ ☐ Original Lien ☐ Amended Lien
MM/DD/YYYY

EAMS CASE NUMBER
Case No.

(Choose only one)

☐ a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

INJURED WORKER'S SSN
SSN (Numbers Only)

_____
(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

INJURED WORKER'S FIRST NAME
First Name

MI

INJURED WORKER'S LAST NAME
Last Name

INJURED WORKER'S ADDRESS
Address/PO Box (Please leave blank spaces between numbers, names or words)

INJURED WORKER'S CITY
City State Zip Code

Attorney/Representative for Injured Worker:

NAME OF INJURED WORKER'S ATTORNEY
Name

ATTORNEY ADDRESS
Address/PO Box (Please leave blank spaces between numbers , names or words)

ATTORNEY CITY
City State Zip Code

Lien Claimant (Completion of this section is required):

NAME OF ORGANIZATION FILING LIEN
Name of Organization filing lien (for individual lien claimants, leave blank)

FIRST NAME OF CONTACT
First Name of Individual filing lien(organizational lien claimants, leave blank)

LAST NAME OF CONTACT
Last Name of Individual filing lien(organizational lien claimants, leave blank)

ORGANIZATION ADDRESS
Address/PO Box (Please leave blank spaces between numbers, names or words)

ORGANIZATION CITY
City State Zip Code

Phone

Lien Claimant's Attorney/Representative, if any

☐ Law Firm/Attorney ☐ Non-Attorney Representative ☐ Lien Claimant not represented

LIEN CLAIMANT LAW FIRM OR REPRESENTATIVE - USE UNIFORM ASSIGNED NAME

Lien Claimant Law Firm/Representative

REPRESENTATIVE FIRST NAME

First Name

REPRESENTATIVE LAST NAME

Last Name

LAW FIRM OR REPRESENTATIVE ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

LAW FIRM OR REPRESENTATIVE CITY

City State Zip Code

LAW FIRM OR REPRESENTATIVE PHONE

Phone

Employer

NAME OF COMPANY INJURED WORKER WAS WORKING FOR

Name

COMPANY ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

COMPANY CITY

City State Zip Code

Insurance Carrier or Claims Administrator

CLAIMS ADMINISTRATOR - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

ADMINISTRATOR CITY

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

ADMINISTRATOR LAW FIRM - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR LAW FIRM ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

ADMINISTRATOR LAW FIRM CITY

City State Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as
Total Lien Amount
compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box):

SELECT ONE OR MORE REASONS

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- ☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

- ☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

TODAY'S DATE

_____	_____	_____
(Signature of Attorney/Representative for Lien Claimant)	(Signature of Lien Claimant)	Date (MM/DD/YYYY)

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of YOUR COUNTY California. I am over the age of eighteen years, my (business/residence) address is:

PUT YOUR HOME ADDRESS HERE

_____

_____

On TODAY'S DATE, I served the attached NAME OF DOCUMENT on the INSURANCE COMPANY in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at CITY WHERE YOU MAILED THIS addressed as follows _____

_____

_____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) TODAY'S DATE, at CITY California.

Type or print name PRINT YOUR NAME _____

Signature SIGN YOUR NAME _____

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of _____ California. I am over the age of eighteen years, my (business/residence) address is:

_____

_____

On _____, I served the attached _____ on the _____ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at _____ addressed as follows _____

_____

_____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) _____, at _____ California.

Type or print name _____

Signature _____