

State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

WC-369 r. 6/17/2015

**ANSWER TO
APPLICATION FOR REVIEW OR
MODIFICATION OF FORMAL AWARD**

☐

ORIGINAL ANSWER

☐

AMENDED ANSWER

Case No.: _____

Vicinity: _____

PETITIONER

SOCIAL SECURITY OR IDENTIFICATION NUMBER:

NAME:

ADDRESS:

VS

RESPONDENT

NAME:

ADDRESS:

CORRECT NAME OF RESPONDENT IF INCORRECT ON CLAIM PETITION:

ATTORNEY FOR
RESPONDENT

NAME:

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

INSURANCE CARRIER OR
SELF-INSURED ENTITY

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

THIRD PARTY
ADMINISTRATOR

NAME:

ADDRESS:

TPA CLAIM NUMBER:

TO THE DIVISION OF WORKERS' COMPENSATION:

**Respondent, in answer to the Application for Review
or Modification, respectfully states:**

Permanent Disability for prior award was paid from:

_____ to _____ for a total of _____ weeks, _____ days at \$ _____ per week, totaling \$ _____.

Temporary Benefits paid subsequent to satisfaction of prior award:

_____ to _____ for a total of _____ weeks, _____ days at \$ _____ per week, totaling \$ _____.

Medical Benefits paid subsequent to satisfaction of prior award:

_____ to _____, totaling \$ _____.

The date of the last compensation payment was _____. The date of the last authorized treatment was _____.

The factual, legal and medical reasons for denying the application are as follows:

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See Attached For Additional Information

☐ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies [N.J.A.C. 12:235-3.8 (c)]

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

Attorney for Respondent

Date