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PETITION FOR BENEFIT DETERMINATION

Tennessee Division of Workers' Compensation
www.tn.gov/labor-wfd/wcomp.shtml
wc.courtclerk@tn.gov
1-800-332-2667

Docket #: _____

StateFile#/YR:_____ /_____

RFA #: _____

Date of Injury: _____

SSN: _____

PLEASE COMPLETE ALL INFORMATION FOR INJURIES ON OR AFTER JULY 1, 2014:
(FORM MUST BE TYPED)

THIS PETITION IS FOR: (PLEASE CHECK ALL THAT APPLY)

- ☐ Temporary disability benefits
- ☐ Medical benefits for current injury
- ☐ Medical benefits under prior order
- ☐ Discovery
- ☐ Permanent Disability Benefits (Employee is at Maximum Medical Improvement)
- ☐ Mediation for increased benefits
- ☐ Approval of a settlement
- ☐ Death Benefits Dependent Children? ☐ Yes ☐ No

Brief Explanation of any Disputed Issues:

_____
_____
_____

Employee Name _____
Address_____
City_____ State_____ Zip Code_____
County of Residence _____
Date of Injury _____
Date of Birth _____ Social Security No. _____
Phone No. _____Fax No. _____
Email Address _____

Employer Name_____
Address_____
City_____ State_____ Zip Code_____
Employer County_____
Phone No. _____Fax No. _____
Email Address_____
Contact Person _____
Contact Person's Email Address_____

Employee's Attorney _____
BPR Number_____
Address_____
City_____ State_____ Zip Code_____
Phone No. _____Fax No. _____
Email Address_____
Contact Person _____
Contact Person's Email Address_____

Employer's Attorney _____
BPR Number_____
Address_____
City_____ State_____ Zip Code_____
Phone No. _____Fax No. _____
Email Address_____
ContactPerson _____
Contact Person's Email Address_____

Insurance Carrier_____
Third Party Administrator_____
Address_____
City_____ State_____ Zip Code_____
Primary Adjuster for Claim_____
Phone Number_____Fax Number_____
Email Address_____
Claim Number_____

DESCRIPTION OF INJURY
Employee's Job/Occupation on Date of Injury/Illness
_____
Name of Body Parts Injured or Description of Occupational Disease:
_____
Where did the Injury/ Illness Occur:
County_____ State_____
Brief Description of How Injury/Illness Occurred:
_____
_____

The Petitioner, _____, alleges that a dispute among the parties exists in this case and requests that the matter be set for mediation.

Employee Name: _____ SF#: _____ DOI: _____

MEDICAL CARE

Has the Employee Been Provided a Panel of Physicians? ☐ Yes ☐ No If yes, Name Physican Selected _____
Has the Employee Been Issued a Permanent Impairment Rating? ☐ Yes ☐ No
If so, please provide the Maximum Medical Improvement (MMI) date, the Impairment Rating and a copy of the Final Medical Report (Form C-3OA), if available _____
Name all doctors seen for this injury: _____
Brief Description of Medical Care Provided: _____

DATE SELECTIONS FOR EMPLOYEE'S AT MMI ONLY

The Parties have discussed possible dates for conducting the mediation and **all** parties have agreed upon the three dates and times listed below.

_____ _____ _____

Time zones provided are ☐ Central ☐ Eastern

FOR SETTLEMENT APPROVALS ONLY, PLEASE CALL THE LOCAL OFFICE TO VERIFY AVAILABILITY.

WAGE AND TEMPORARY DISABILITY INFORMATION

Number of Weeks (if any) requested for Temporary Disability Benefits _____
Employee's Average Weekly Wage on Date of Injury: $_____/per week
Has the Employee Returned to Work? ☐ Yes ☐ No

THE SECOND INJURY FUND (SIF):

Is the Second Injury Fund (SIF) involved in this claim? Yes ☐ No ☐ Unknown ☐
If the SIF is already involved, please name the SIF attorney: _____
To preserve a claim against the SIF, you must fax a copy of this form to the SIF fax number 615-741-4169 or mail a copy to: Legal Services Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

DOCUMENTATION OF CLAIM

TO SUPPORT THIS PETITION, I HAVE INCLUDED THE FOLLOWING:

☐ If medical treatment has been denied, please provide a copy of the denial.
☐ ALL relevant medical records including office notes, test results, physical therapy notes and physician's letters.
☐ If you are requesting temporary disability benefits, please include a note from your physician removing you from or restricting your work duties.
☐ If you are requesting payment of medical bills, please provide copies of itemized bills and the medical records related related to these bills.
☐ If payment of mileage is being requested, please provide dates and proof of medical visit as well as round trip mileage amount. *(Please provide a separate attachment with mileage amounts.)*
☐ Job Description of Employee, if available.
☐ Any additional information and/or documentation you would like the Mediator to review.

STATEMENT

I, the Petitioner or the Petitioner's representative, affirm that the information provided in this petition for benefit determination is true and accurate to the best of my knowledge, information and belief.

_____ _____
Signature Date

The undersigned certifies on this ___ day of _____,20____a true and correct copy of the Petition for Benefit Determination has been forwarded via facsimile, email and/or U.S. Mail, first class postage prepaid to:

☐ Employee _____
☐ Employee's Attorney, _____
☐ Employer, _____
☐ Employer's Attorney, _____
☐ Carrier/Adjuster, _____

_____
Signature
_____
Printed Name

TENNESSEE DEPT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
http://www.tn.gov/labor-wfd/wcomp.html
Toll Free: 1-800-332-2667

Please return the completed form to the office listed below that is closest to the home address of the Employee.

If you need help completing this form, please call the toll free number listed above.

CHATTANOOGA

WORKERS' COMPENSATION DIVISION
1301 Riverfront Pkwy., Suite 202
Chattanooga, TN 37402
Phone: 423-634-6422
Fax: 423-634-3115

KINGSPORT

TDLWD/WORKERS' COMPENSATION DIVISION
1908 Bowater Drive
Kingsport, TN 37660-4136
Phone: 423-224-2057
Fax: 423-224-2056

KNOXVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
520 Summit Hill, Suite 103
Knoxville, TN 37902
Phone: 865-594-5177
Fax: 865-594-5172

COOKEVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
444 – A Neal Street
Cookeville, TN 38501-4027
Phone: 931-520-4290
Fax: 931-520-4316

MURFREESBORO

TDLWD/WORKERS' COMPENSATION DIVISION
845 Esther Lane
Murfreesboro, TN 37129-5537
Phone: 615-848-6743
Fax: 615-217-9378

NASHVILLE

TDLWD/WORKERS' COMPENSATION DIVISION
220 French Landing Dr.
Nashville, TN 37243
Phone: 615-741-1383
Fax: 615-253-1223

JACKSON

TDLWD/WORKERS' COMPENSATION DIVISION
225 Dr. Martin L. King Jr. Drive
1st Floor, Suite 120, Box 26
Jackson, TN 38301-6985
Phone: 731-423-5646
Fax: 731-265-7022

MEMPHIS

TDLWD/WORKERS' COMPENSATION DIVISION
One Commerce Square
40 South Main Street, Suite 500
Memphis, TN 38103-1820
Phone: 901-543-6077
Fax: 901-543-6039