



REPORT OF CLAIM STATUS / REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

State Form 38911 (R4 / 5-97)

PRIVACY NOTICE

*This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

Accident number

INSTRUCTIONS: Complete **appropriate** sections of this document and sign in the space below.

CLAIM INFORMATION			
Name of employer	Federal I.D. Number	Address of employer	Telephone number ()
Name of insurer		Insurer claim number	Date of injury
Address (city, state, ZIP code)		Telephone number ()	Telephone number ()
Name of employee	*Social Security Number	Address of employee	()

BENEFIT TERMINATION / DENIAL NOTICE (check appropriate action)

Notice of denial must be made in writing and mailed not later than twenty nine (29) days after the employer's knowledge of the injury (IC 22-3-3-7). Report compensation payments in the appropriate section below, if applicable.

- Return to work
- Claim deemed not compensable
- Benefit termination (see compensation payments section below)
- Refusal to accept medical treatment, services and supplies, provided by or on behalf of your employer, shall bar your compensation otherwise payable during the period of refusal (IC 22-3-3-4).
- Refusal to allow an autopsy shall result in a suspension of all compensation (IC 22-3-3-6).
- Refusal to accept employment suitable to your partial disability shall bar any compensation during such refusal unless, in the opinion of the Worker's Compensation Board of Indiana, such refusal was justified (IC 22-3-3-11).
- Other (specify) _____

If the employee disagrees with the proposed termination, the employee must give a written notice to the Worker's Compensation Board and employer within seven (7) days after receipt of this termination notice (IC 22-3-3-7). See Independent Medical Examination Request section below.

COMPENSATION PAYMENTS

All compensation payments should be reported to the Board on the below prescribed form (IC 22-3-3-7).

No. wks. paid	Paid to: (name)	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	Total amount paid \$	Beginning date of payments	Ending date of payments
Reason(s) for ending payments					
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> PPI <input type="checkbox"/> PTD					

INDEPENDENT MEDICAL EXAMINATION REQUEST

Employees who disagree with proposed benefit termination must serve a copy of this disagreement notice to the **Worker's Compensation Board** and **the employer** within **seven (7) days** after receipt of the termination portion of this notice. Please sign below to make an independent medical examination request. An employee may request an independent medical examination to resolve a medical issue dispute.

- | | |
|--|--|
| Employee disagrees with proposed termination: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employee requests independent medical examination: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer requests independent medical examination: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MAIL TO:

Worker's Compensation Board
402 W. Washington St. Rm. W196
Indianapolis, IN 46204-2753

EMPLOYER CERTIFICATION / RECEIPT OF EMPLOYEE / DEPENDENT

Employer and employee must sign below to certify service or acknowledge receipt of this notice.

Signature of employer X		Signature of employee X	
Date signed (month, day, year)	By: <input type="checkbox"/> U.S. Mail <input type="checkbox"/> Personal service	Date signed (month, day, year)	By: <input type="checkbox"/> U.S. Mail <input type="checkbox"/> Personal service