Workers' Compensation Case Questionnaire

(Privacy Act Release must be obtained for all cases)

Name:_____

Address:_____

Workers' Compensation Claim Number:_____

Social Security Number:(_____)_____

Type of Case:

_____workers' comp claim pending
_____workers' comp claim denied/appeal pending
_____medical bills reimbursement claim pending
_____medical bills reimbursement claim denied/appealing
_____other_____

Description of Case:_____

_____

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*****Note: Please be certain you print a Privacy Act form, complete, sign, and return it to the state office nearest you. A map is available to help you make that determination, along with the addresses of each state office.**