NOTICE OF CLAIM STATUS

Injured Worker:		Social Security Number:
Worker's Address:	City, State:	ZIP:
Date of Injury:		
Employer:		
Insurance Company:		

This is to notify you of the denial or change of status of your workers' compensation claim as indicated in the statement checked below:

☐ Your claim is denied. Reason:

☐ Your benefit payments will be:

☐ Reduced ☐ Increased Effective Date: Reason:

☐ Your benefit payments will be stopped.

Effective Date: Reason:

☐ Your claim is being investigated. A decision should be made by .

☐ Other: Effective Date:

Explanation:

☐ See attached medical reports.

Signature of insurance company adjuster examiner.

Name (Typed or Printed): Date: