NOTICE OF CHANGE OF STATUS

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

This is to notify you of a change in your workers' compensation claim as indicated below.

Your claim is:

☐ Accepted

☐ Being investigated, and a decision should be made by: _____

☐ Denied. Reason: _____

Your benefit payments will be:

☐ Increased

☐ Decreased

☐ Terminated

Effective: _____ Reason: _____

Other: _____

☐ See attached medical reports

☐ Your claim is being administratively closed. Please contact me prior to seeking additional medical treatment.

Signature of adjuster/examiner: _____ Date: _____

E-mail Address: _____ Phone: _____