WORKERS' COMPENSATION BOARD

S20085

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) PD-Partial Denial

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

The Claim Administrator has denied indemnity benefits in part or whole but is not denying medical benefits. If Claim Administrator denies medical benefits, they will file Form C-8.1

Employee Name JOHN DOE Scenario 5-3

WCB Case Number (JCN) G0055555

Date of Injury 08/01/2012

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 08/27/2012

Claim Type L - Became Indemnity for Lost Time

WCB Received Date 02/01/2013

Agreement to Compensate

INSURER INFORMATION

FEIN xxxxx6789

Insurer ID W123456

CLAIM ADMINISTRATOR INFORMATION

Name ALL AMERICAN INSURANCE COMPANY

FEIN xxxxx6789

Claim Representative Name MARY CLARK

Postal Code 12110

Business Phone Number 5187855000

Fax Number 5187855001

E-mail Address mclark@allamerican.com

Claim Admin ID W123456

Late Reason

PARTIAL DENIAL REASON

Partial Denial Reason A - Denying Indemnity in Whole, Not Medical

Denial Reason Narrative

Clt is OOW per employer but Clt & Dr have not provided any medical reports

EMPLOYEE INFORMATION

First Name JOHN

Middle Name/Initial

Last Name DOE Scenario 5-3

Suffix

Date of Birth 11/01/1977

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx6745

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 08/16/2012

Employment Status 1 - Full Time

Pre-existing Disability No

Number of Days Worked Per Week 5

Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	S	S	S	S	S	N

Work Week Type S - Standard Work Week

Calculated Wage $1,050.00

Wage Period 01 - Weekly

Calculated Weekly Compensation Amount $700.00

Anticipated Wage Loss

Employer Paid Salary Prior To Acquisition

Denial Rescission Date

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation No

Type of Loss 01 - Trauma

Date of Maximum Medical Improvement

Death Result of Injury

Date of Death

Number of Dependents

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Disability Began

Initial Date Disability Began 08/02/2012

Latest Return to Work Status Date

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Benefits

Benefit Types

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date ______________

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name ______________ **Contact Business Phone** ______________ **Wage** ______________