NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE:

TO: **[NAME OF INJURED EMPLOYEE]**
[ADDRESS]
[CITY, STATE, ZIP]

RE: **[DATE OF INJURY]**
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM #]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP]

On (date of carrier receipt of notice of injury) we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

(***Provide full and complete statement explaining the action taken________________________
____
____
____***)

If you do not agree with the denial and refusal to pay benefits, please contact me:

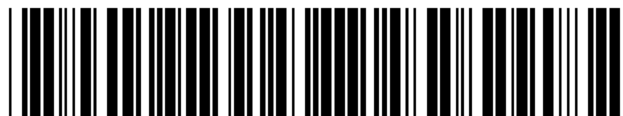
Adjuster's Name: ______________________________
Toll Free Telephone #: ______________________________
Fax #/E-mail Address: ______________________________

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:



INSTRUCTIONS:

Notification of Denial of Compensability/Liability and Refusal to Pay Benefits (DWC FORM PLN-1) Rule 124.2(d); (MTC: 04)

This letter must be used to notify the employee/representative and the Division of the carrier's denial of compensability of, or liability for, an injury. **It must be filed in addition to the 148/04 or A49/04 in order to provide the basis of the dispute when a denial of compensability/liability is filed with the Division. The DWC FORM PLN-1 and the appropriate 04 transaction should be filed simultaneously. The notice of denial is not considered complete until both filings have been received by the Division.**

Provide a full and complete statement of the facts surrounding the claim that justify and serve as the grounds for the denial of compensability or liability for the claim.

EXAMPLES:

- Our investigation finds the injured worker sustained the injury at his son’s little league game when he fell off the bleachers. He was taken to the local hospital by ambulance. Video tape of accident and news broadcast are available for review by interested parties.

- We deny liability for the injury due to lack of workers’ compensation insurance coverage by the employer. We have never provided workers’ compensation coverage to the employer and are not liable for payment of benefits.

NOTE:

A statement that simply states a conclusion such as “liability in question”, “compensability in dispute” or “under investigation” is insufficient grounds for the information required per Rule 124.2(h).

Denials must be based upon information a carrier has obtained or verified, not what it has not been able to verify.

MAIL THIS FORM TO DWC IN LIEU OF A DWC FORM-21 WHEN YOU HAVE FILED AN ELECTRONIC MTC 04