TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
Distribution of this form will be in accordance with Rule 133.304
DO NOT SEND THIS FORM TO DWC UNLESS DWC SPECIFICALLY REQUESTS IT.
An insurance carrier may substitute its own EOB form, but it MUST contain all fields required by DWC.

CLAIM #_____

Carrier's Claim # _____

EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address	
6. Health care provider's name and address	7. Insurance carrier's name and address	
8. Health care provider's federal tax I.D. number	Insurance carrier payment to the health care provider shall be according to Division medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under §408.024 of the Texas Workers' Compensation Act.	
9. Name and address of the company performing the audit		
Date of the audit:		
10. Name and telephone number of the person who can be contacted about the bill reduction:		

DOS	CPT / Rev Code	Type of Service	ICD-9 Code	Units	Charges	Amount Paid	ANSI Reason Code	Text to explain Reason for Reduction / Denial

DOS: date of service
The complete ANSI Claim Adjustment Reason Code set is available on the Washington Publishing Company Website at www.wpc-edi.com.