

# REPORT OF CLAIM STATUS REQUEST FOR INDEPENDENT MEDICAL EXAMINATION State Form 38911 (Ref / 5-87)

PRIVACY NOTICE

"This agency is requesting disclosure of your Social Security number in accordance with IC 22:3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

Acci dent num ber

INSTRUCTIONS- Complete appropriate sections of this document and sign in the space below

Name of insurer claim number   C   C   Code of injury			CILAIM	INFORMATION		
Debe of injury  Address (oty, state, ZIP code)  Telephone number  ( )  Telephone  (	Name of employer Feder		Federal I.D. Number			
Telephone number address of employee    Social Security Number   Address of employee   Telephone number   Telephone number	Name of insurer			Insurer claim number		This is a second to the second
Severity Number   Address of employee	Address (city, state, ZIP code)					
Notice of denial must be made writing and mailed not later than twenty nine. (29) days after the employer's knowledge of the injury (10: 22-3-7). Report compensation payments the appropriate section below, if applicable.  Return to work.  Claim deemed not compensable.  Benefit termination (see compensable.)  Refusal to accept medical treatment, services and supplies, provided by or on behalf of your employer, shall bar your compensation otherwise payable during the period of refusal (10: 22-3-3-4).  Refusal to accept employment suitable to your partial disability shall bar any compensation during such refusal unless, in the opinion of the Worker's Compensation Board of inclana, such refusal was justified (10: 22-3-3-1).  Other (specify)  If the employee disagrees with the proposed termination, the employee must give a written notice to the Worker's Compensation Board and employer within severa (7) days after receipt of this termination notice (10: 22-3-3-7). See independent Medical Economistion Required section below.  COMPENSATION PAYMENTS  All compensation payments should be reported to the Board on the below prescribed form (10: 22-3-3-7).  Employees who disagree with proposed benefit termination must serve a copy of this disagreement notice to the Worker's Compensation Board and the employer within (7) days after receipt of the termination payments.  Employees who disagree with proposed benefit termination must serve a copy of this disagreement notice to the Worker's Compensation an independent employee may request an independent medical examination to resolve a medical examination to resolve a medical examination.  Employer and employee must sign below to certify service or acknowledge necept of this notice.  Employer and employee must sign below to certify service or acknowledge necept of this notice.  Employer and employee must sign below to certify service or acknowledge necept of this notice.  Employer and employee must sign below to certify service or acknowledge necept of this notice.  Employer and e	Name of emple	syme	"Social Security Number	Address of employee		
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Employer and employee must sign below to certify service or acknowledge receipt of this notice.  Signature of employee  X  See signed (month, day, year)  By: - U.S. Mail Date signed (month, day, year)  By: - U.S. Mail					No Worker 402 W. W	s Compensation Board Vashington St. Rm. W196 lis, IN 46204-2753
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