

# 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 Date of injury			CLAIM	INFORMATION		
Date of injury  Address (oby, state, ZIP code)    Telephone number   Code of injury	Name of employer		Federal I.D. Number			
Telephone number address of employee    Social Security Number   Address of employee	Name of insurer			Insurer claim number		
DENETRY REMINATION   DENIAL NOTICE (check appropriate action)	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). Peper ocorpensation payments the appropriate section below, if applicable.  Refusal to work.  Claim deemed not compensable.  Benefit termination (see compensable payments section below).  Refusal to accept medical resemble period of refusal (10: 22-3-3-4).  Refusal to accept employer shall result in a suspension of all 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 indicana, such refusal was justified (10: 22-3-3-11).  Other (specify)  If the employer disagrees with the proposed termination, the employer must give a written notice to the Worker's Compensation Board and employer within several (7) days after receipt of this termination notice (10: 22-3-3-7). See Independent Medical Board and employer within several (7) days after receipt of the below prescribed form (10: 22-3-3-7).  **Refusal to accept a section below.**  **COMPENSATION PAYMENTS**  All compensation payments should be reported to the Board on the below prescribed form (10: 22-3-3-7).  **Employers who disagree with proposed benefit termination must serve a copy of this disagreement notice to the Worker's Compens Board and the employer within (7) days after receipt of the termination portion of this notice. Please sign below to me an independence medical examination reported and service of the proposed termination.  **Employer disagrees with proposed termination:**  **Employer and employer must sign below	same of empli	cyme	*Social Security Number			
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