

8 Important Letters

1. The claim acceptance or denial letter

If your claim is denied, no medical or compensation benefits will be paid, and the clinic that provided emergency medical care will start billing you. You **must** file a request for hearing within **70** days of the date of the denial letter on the form included with the denial letter. The only excuse the hearings officer can accept for not filing on time is that you can prove that you did not receive the letter and form. You must make sure that you gave your correct address on the C-4 claim form, and that you called the third-party administrator if you moved immediately after filing a claim. If you did move and have not received a denial or acceptance letter within 30 days after you first got medical care and filled out a C-4 form, call and find out if the acceptance or denial letter was sent to your correct address.

If you file an appeal from a claim denial letter, and you lose after the first hearing, you **must** file a further appeal with the Appeals Division within **30** days.

If the letter from the insurer says that the claim is accepted, read what the letter says about what body parts are accepted. If you injured your left wrist, but the letter says that only your left knee is accepted, you need to get an amended acceptance letter, or appeal that letter within **70** days.

2. Average monthly wage letter

This letter is sent when you have been off work for 5 days in a row, or 5 days within a 20-day time period. It tells you what the insurer has calculated your average monthly wage to be, based on wage information provided by your employer. Your benefits will be 66 2/3 of that figure. Even if you were not out of work for long, make sure this figure is correct, as your final award is also based on this figure. If you think the insurer incorrectly calculated your average monthly wage, you need to file an appeal before your claim closes.

3. Letters regarding your medical care

In the first 90 days of the claim, the injured worker can request a different doctor on the insurer's provider list, and the insurer must honor that request. So, if you are unhappy with your clinic or doctor, put a request in writing to the insurer asking for a copy of the provider list. Then, send a request to change your doctor to another one on the list. After your claim is 90 days old, the insurer does not have to change your doctor.

4. Any letter suspending, terminating, or denying benefits

You must file an appeal on the form provided with the letter from the insurer within 70 days or these benefits are forever lost.

5. The letter closing your claim

If you think you need more medical care, you need to file an appeal within 70 days. If the closure letter does not say that you will be scheduled for a rating evaluation, and you think you are entitled to a PPD award, you likewise need to file an appeal, and follow the procedure for obtaining a rating on your own.

6. The letter offering you a PPD award

You need to file an appeal within **70** days if you disagree with the percentage of impairment. Even if you do not disagree with the percentage of impairment, do not elect to take the award in a lump sum if you have filed an appeal or intend to because you think more compensation benefits are due for past time periods, or you want more medical care, or you are trying to get treatment for an additional body part.

7. A letter denying vocational rehabilitation benefits

You need to file an appeal within **70** days as indicated in the letter on the form provided.

8. Letters from medical providers billing you

You want to call and send a letter advising them that you have an accepted workers' comp claim, and give the claim number and name and address of the TPA handling your claim. Medical providers should not bill injured workers, but they will if they do not have claims information.