Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No. _____
Date of Injury _____
Ins. Co. File No. _____

Denial of Workers' Compensation Benefits by Employer or Carrier

Your employer has filed this denial in accordance with Vermont Workers' Compensation Rule 3.0900. Notice must be sent to the injured worker and the Department of Labor. **Supporting evidence must be attached.**

TO:
Claimant's Name: _____

Address: _____ Telephone No.: _____

Employer: _____ Date of Injury: _____

Date Notice of Injury Received by Employer: _____

Body Part Injured/Injuries Reported to Carrier: ☐

☐ Entire Claim Denied ☐ Indemnity Benefits Denied ☐ Medical Benefits Denied

Specify grounds for denial and give a brief statement of the specific facts supporting the grounds for denial.

☐ **DOCUMENTS ATTACHED**

A. ☐ Medical Bill not Related to Accepted Injury. _____

B. ☐ No Injury Arising Out of and in the Course of Employment. _____

C. ☐ No Indemnity Due. _____

D. ☐ No Causal Relationship Between Injury and Disability. _____

E. ☐ Medical Release (Form 7) Not Returned by Claimant. _____

F. ☐ Treatment is Not Reasonable, Necessary or Related to the Injury _____

G. ☐ Preauthorization of Medical Treatment _____

H. ☐ Other (Specify): _____

Issued By:
Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No. _____

Adjuster Signature: _____ Employer _____

Date Notice Sent to Claimant: _____

NOTICE and FORM for EMPLOYEE to APPEAL DENIAL

TO APPEAL, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE (for example, doctor's notes, emergency room records, any other medical records such as physical therapy, radiology reports, etc. or witness statements) TO SUPPORT YOUR INJURY AROSE OUT OF YOUR WORK. KEEP A COPY OF THE FORM FOR YOUR RECORDS AND MAIL A COPY OF THIS FORM TO The Department of Labor at the address above and the Insurance Carrier.

Did you notify your employer/supervisor of the injury/illness? Yes _____ No _____
Briefly explain how the injury/illness occurred (attach additional pages if necessary):

_____

Did you lose time from work because of the injury? Yes _____ No _____
If yes, on what date did you begin losing time from work? _____
If you have returned to work, indicate the date on which you returned. _____

Pleases check off and attach documents that you are relying on for your appeal:

- ☐ treatment notes from each office visit you had with any medical provider
- ☐ emergency room records
- ☐ radiology reports (not films)
- ☐ chiropractic records
- ☐ physical therapy notes
- ☐ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

I am seeking all workers' compensation benefits allowed by law.

_____
Employee Signature Date Signed

If you have further questions please call or office at (802) 828-2286 or check our web-site at www.labor.vermont.gov

Equal Opportunity is the Law. The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711(TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).