Claim Form

Access your claim online: webfile.workcomp.virginia.gov

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Injured Worker Information

Name

Address

City | State | Zip Code

Primary Phone | Gross Weekly Earnings

Employer Information

Name of Company

Address

City | State | Zip Code

Employer's Phone

Injury

Date of Injury* | Where Injury Occured (City or County)

Parts of Body Injured

How Injury Occurred

***If claiming an occupational disease** (use separate claim form for Coal Workers' Pneumoconiosis)**:**

Name of Occupational Disease | Date last worked for employer | Date doctor stated the disease was caused by work

Request for Benefits

I need assistance obtaining the following benefits. If the benefits are denied, this form will serve as a hearing request.

☐ Lifetime Medical Award (coverage for related medical expenses).

☐ Wage Loss Replacement (Temporary Total Disability - Completely out of work):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Compensation for Permanent Loss (Permanent Partial Disability):

☐ Loss of use of a body part ☐ Disfigurement/Scarring ☐ Amputation ☐ Hearing/Vision loss ☐ Lung disease

☐ Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):

☐ Medical bills ☐ Mileage/Transportation ☐ Prescriptions

☐ Death benefits to dependents and/or funeral expenses.

☐ Other: _____

Signature

I hereby file this claim to protect my right to benefits under the Virginia Workers' Compensation Act for the injury or disease described above.

SIGNATURE (Required) PRINT DATE

Claim Form Process & Instructions

Injury

When an individual has experienced an injury or an occupational disease in the workplace, it is important to give immediate notice to the employer about the injury. Employers are required to file a First Report of Injury (FROI) within ten (10) days of having knowledge of any injury.

Claim Form

Pursuant to Va. Code §65.2-601, a claim for specific benefits must be filed within two (2) years from the date of injury. Even if the Claim Administrator is voluntarily paying benefits, rights are not protected unless there is an Award Order.

Award Order

If the Claim Administrator accepts the claim, an Award Agreement is sent to the injured worker. Once signed by all parties, the Award Agreement must be filed with the Commission for entry of the Award Order. An Award Order protects the injured worker's rights to benefits.

Alternative Dispute Resolution (ADR)

Mediation is a voluntary and confidential informal dispute resolution process where a neutral third party (mediator) facilitates communication to assist the parties in mediating an agreeable solution. The purpose of mediation is to identify issues, clarify misunderstandings, explore solutions and mediate an agreement. For further information, contact the ADR Department at 804-205-3139.

Hearing

A hearing may be necessary to resolve disputed issues. A completed Claim Form and medical records* to support the claim must be filed for this to occur. The primary objective is to hear and decide disputed claims and issues arising under the Virginia Workers' Compensation Act in a prompt, fair and impartial manner.

*Medical Records & Subpoenas

Copies of medical records may be obtained from the physician. However, if copies of medical records and/or bills cannot be obtained, a subpoena can be requested by sending the name and address of the medical provider to the Clerk of the Commission. A $12 money order made payable to the Sheriff of the city or county where the medical provider is located must be included for each subpoena.

Benefits Covered under the Virginia Workers' Compensation Act

- **Lifetime Medical** - payment for medical treatment/expenses for the injury or occupational disease, now and in the future.
- **Temporary Total Disability -** wage loss replacement while completely out of work. Must be medically authorized.
- **Temporary Partial Disability -** wage loss replacement while partially out of work, or working light duty. Must be medically authorized.
- **Permanent Partial Disability -** compensation for loss of use of a body part, amputation, disfigurement/bodily scarring, loss of hearing, loss of vision or lung disease. Must be medically supported.
- **Medical Expenses -** payment/reimbursement of medical bills, or out of pocket expenses, such as prescription and mileage/transportation. Must provide bills, receipts and/or mileage logs.
- **Death Benefits -** payment/reimbursement of funeral/transportation expenses or wage loss replacement for surviving spouse, children, or certain other dependents. Death Certificate, Marriage License and/or Birth Certificate(s) must be provided.
- **Other -** benefits not previously mentioned (vocational rehabilitation, specific medical treatment/procedure, panel of physicians, etc).