REQUEST FOR BENEFIT REVIEW CONFERENCE

STAMP-DATE RECEIVED

TENNESSEE DEPT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
http://www.tn.gov/labor-wfd/wcomp.html
Toll Free Help Line: 1-800-332-2667

SF # _____

RFA # _____

PLEASE NOTE: ALL FIELDS MARKED WITH AN ASTERISK *ARE MANDATORY
Failure to complete the required information on this form will result in the form being returned to the requesting party for completion.

A) * **THIS REQUEST is FOR:** (Please indicate **ONE** purpose only.)

☐ Mediation; Employee **has reached Maximum Medical Improvement** and parties **are ready** to proceed to Benefit Review Conference. (A completed Certificate of Readiness – C40R Form is attached.)

☐ Statute of Limitations purposes; the Employee **has reached Maximum Medical Improvement**, but parties **are not ready** to proceed. (A completed C40R Form shall be submitted once parties are fully prepared to mediate this claim.)

☐ Statute of Limitations purposes; the Employee **has not reached Maximum Medical Improvement**. (A completed C40R Formshall be submitted once parties are fully prepared to mediate this claim.)

☐ Reconsideration of previous settlement under State File #: _____ Date of Injury: _____

B) * Is the **Second Injury Fund** involved in the Settlement of this Claim? **Yes** ☐ **No** ☐ **Unknown** ☐

If yes, Please name SIF ATTORNEY**:** _____

To preserve a claim against the SIF, you must fax a copy of this form to TDL&WD Legal Office fax number 615-741-4169 or mail a copy to: Legal Services Director, TDL&WD Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

C) * **SOCIAL SECURITY #** _____ * **DATE of INJURY** _____

* **EMPLOYEE'S NAME:** _____ * **DATE of BIRTH** _____

* Mailing Address: _____

* City: _____ * State: _____ * Zip: _____

* County of Residence: _____ * Telephone: _____ Email: _____

* ***If the Employee is represented by an attorney, all fields in this section are mandatory.***

EE's ATTORNEY: _____ **BPR#:** _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

D) * **EMPLOYER'S NAME:** _____ * Contact: _____

* Mailing Address: _____

* City: _____ State: _____ Zip: _____

* Telephone: _____ * Fax: _____ * Email: _____

*_If the Employer is represented by an attorney, all fields in this section are also mandatory._

ER's ATTORNEY: _____ **BPR#:** _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

E) * INSURANCE CARRIER: _____

* **CLAIM HANDLER**: _____ * CLAIM#: _____

* **Adjuster's Name**: _____

* Adjuster's Mailing Address: _____

* City: _____ * State: _____ * Zip: _____

* Telephone: _____ * Fax: _____ * Email: _____

F) * BRIEF DESCRIPTION of INJURY: _____

_____

* County of Injury: _____ * Did the Employee return to work for the same Employer? **Yes** ☐ **No** ☐

* This Employee worked for this Employer: **Years** _____ **Months** _____ * Does Employee still work for this Employer? **Yes** ☐ **No** ☐

* Please give a brief explanation of the disputed issues: _____

_____

G) MEDICAL TREATMENT:

* Did the Employee receive payment of Temporary Disability Benefits? **Yes** ☐ **No** ☐

* Was there an impairment rating assigned by the Authorized Treating Physician? **Yes** ☐ **No** ☐

* Was there an impairment rating assigned by an Independent Medical Examination? **Yes** ☐ **No** ☐

* Was there an impairment rating assigned through the Medical Impairment Rating Registry? **Yes** ☐ **No** ☐

Submitting this form and attaching all pertinent medical information and relevant documents to the other parties as well as this Division will help to expedite the Benefit Review process.

REQUESTING PARTY

I hereby request the Department of Labor and Workforce Development to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Department of Labor and Workforce Development to contact any person who has information regarding that injury. If the requesting party is the Injured Employee or the Injured Employee's legal representative, authorization is also given to the Department of Labor and Workforce Development to use the Injured Employee's social security number in a manner necessary to provide the requested assistance. Further, by signature the requesting party or the party's representative certifies that each of the above-detailed answers is true. It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

☐ ***BY CHECKING THE BOX AND SIGNING BELOW, THE REQUESTING PARTY CERTIFIES THAT A COMPLETED COPY OF THIS REQUEST FOR BENEFIT REVIEW CONFERENCE HAS BEEN FORWARDED TO THE OPPOSING PARTIES**

***PRINT NAME:** _____ ***SIGNATURE:** _____

***DATE:** _____

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Please return the completed form to the office listed below that is closest to the home address of the Employee named in Section C of the Request for Benefit Review Conference (C40B form).

If you need help in completing this form, please call the office nearest you or our toll-free help line listed above.

CHATTANOOGA

WORKERS' COMPENSATION DIVISION
1301 Riverfront Pkwy., Suite 202
Chattanooga, TN 37402
Phone: 423-634-6422
Fax: 423-634-3115

KINGSPORT

WORKERS' COMPENSATION DIVISION
1908 Bowater Drive
Kingsport, TN 37660-4136
Phone: 423-224-2057
Fax: 423-224-2056

KNOXVILLE

WORKERS' COMPENSATION DIVISION
520 Summit Hill, Suite 103
Knoxville, TN 37902
Phone: 865-594-5177
Fax: 865-594-5172

COOKEVILLE

WORKERS' COMPENSATION DIVISION
444 – A Neal Street
Cookeville, TN 38501-3791
Phone: 931-520-4027
Fax: 931-520-4316

MURFREESBORO

WORKERS' COMPENSATION DIVISION 845
Esther Lane
Murfreesboro, TN 37129-5537
Phone: 615-848-6743
Fax: 615-217-9378

NASHVILLE

WORKERS' COMPENSATION DIVISION
220 French Landing Dr.
Nashville, TN 37243
Phone: 615-741-1383
Fax: 615-253-1223

JACKSON

WORKERS' COMPENSATION DIVISION 225 Dr.
Martin L. King Jr. Drive
1st Floor, Suite 120, Box 26
Jackson, TN 38301-6985
Phone: 731-423-5646
Fax: 731-265-7022

MEMPHIS

WORKERS' COMPENSATION DIVISION
One Commerce Square
40 South Main St., Suite 500
Memphis, TN 38103-1820
Phone: 901-543-6077
Fax: 901-543-6039