

## 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. |  |

Rev. 9/11

DOL FORM 2

## 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.** 

| injured worker and the Department of Labor. <b>Support</b> | ing evidence must be attached.   |  |  |
|--|--|--|--|
| TO:<br>Claimant's Name:                                    |  |  |  |
| Addraga  | Telephone No.:   |  |  |
| Employer:  | Date of Injury:  |  |  |
| Date Notice of Injury Received by Employer:                |  |  |  |
| Body Part Injured/Injuries Reported to Car                 | rier:  |  |  |
| ☐ Entire Claim Denied ☐ Indemnity Benefits                 | s Denied Medical Benefits Denied tement of the specific facts supporting the grounds for denial. |  |  |
| _  | ement of the specific facts supporting the grounds for demai.                                    |  |  |
| DOCUMENTS ATTACHED   | 17.  |  |  |
| A. Medical Bill not Related to Accepte                     | ed Injury.   |  |  |
| B.   | Course of Employment.  |  |  |
| C. No Indemnity Due.                                       |  |  |  |
| D. No Causal Relationship Between In                       | ijury and Disability.  |  |  |
| E.   | Release (Form 7) Not Returned by Claimant.   |  |  |
| F. Treatment is Not Reasonable, Neces                      | nent is Not Reasonable, Necessary or Related to the Injury                                       |  |  |
| G. Preauthorization of Medical Treatm                      | nent   |  |  |
| H. Other (Specify):  |  |  |  |
| Issued By:   |  |  |  |
| Carrier:   | Administrator (if not carrier):  |  |  |
| Adjuster Name:   | Telephone No.  |  |  |
| Adjuster Signature:  | Employer   |  |  |
| Date Notice Sent to Claimant:                              |  |  |  |

| DOL Form 2 | Page 2 of 2 | State File Number: |
|------------|-------------|--------------------|
|            |             |                    |

## 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 medic<br>etc. or witness statements) TO SUPPORT YOUR INJUR<br>OF THE FORM FOR YOUR RECORDS AND MAIL A<br>at the address above and the Insurance Carrier.  | Y AROSE OUT OF YOU           | R WORK. KEEP A COPY         |
|---|------------------------------|-----------------------------|
| Did you notify your employer/supervisor of the injury/illr  | ness? Yes                    | No                          |
| Briefly explain how the injury/illness occurred (attach add   | litional 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 y  | ou returned.                 |                             |
| Pleases check off and attach documents that you are relying treatment notes from each office visit you had with emergency room records radiology reports (not films) chiropractic records physical therapy notes written clarification from your treating providers a (strongly recommended). | h nay medical provider       | r condition is work-related |
| 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 <a href="https://www.labor.vermont.gov">www.labor.vermont.gov</a>

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).