State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381
WC-368 r.8/26/2015

APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD

☐ **ORIGINAL** ☐ **AMENDED FILING**

Case No.: _____

Vicinage: _____

Case Number Required

PETITIONER

SOCIAL SECURITY NUMBER:

NAME:

ADDRESS:

DATE OF BIRTH: | SEX:

☐ **A guardian or other representative is filing on behalf of the petitioner. See additional page for details.**

ATTORNEY FOR PETITIONER

TAX IDENTIFICATION NUMBER:

NAME:

ADDRESS:

TELEPHONE NUMBER: | FAX NUMBER:

VS

RESPONDENT

NAME:

ADDRESS:

☐ **If uninsured, individual corporate officers, or others, are also named as respondent(s). See Supplemental Page for details.**

INSURANCE CARRIER / TPA

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

☐ **See Supplemental Page for additional carriers**

TO THE DIVISION OF WORKERS' COMPENSATION: _____ (*Name of Petitioner or Respondent*), pursuant to N.J.S.A. 34:15-27 seeks modification and review of the award entered on _____, for the following reasons:

☐ **See Attached For Additional Information**

As to Claim Petitioner:

Date of Injury:	Date of Last Comp. Pd:	Present Employment Status:	Claim Petitions filed since last award:

This is the _____ Application for Review or Modification of this award.
(Number)

☐ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies. [N.J.A.C. 12:235-3.8 (c)]

ARE YOU MEDICARE ELIGIBLE OR A MEDICARE BENEFICIARY? ☐ **YES** ☐ **NO**

WERE YOU ELIGIBLE FOR MEDICAID BENEFITS AT THE TIME OF THE WORK INJURY? ☐ **YES** ☐ **NO**

DID YOU BECOME ELIGIBLE FOR MEDICAID BENEFITS AFTER THE WORK INJURY? ☐ **YES** ☐ **NO**

Summary of Changes (*Complete only if filing an Amended pleading*):

STATE OF NEW JERSEY, COUNTY OF _____

Subscribed and sworn or affirmed
to before me this _____ day of _____ , _____

_____

_____
Applicant

Please be advised that information collected from the filing of this Application for Review or Modification of Formal Award may be used by the Division of Workers' Compensation for record keeping, record access/distribution, and case scheduling purposes. Petitions filed with the Division are public documents and may be inspected and copied except where prohibited by Section 34:15-128 of the Workers' Compensation Statute.

The Privacy Act, 5 U.S.C. §552a, the Social Security Act, 42 U.S.C. § 405, and N.J.S.A. 34:15-1 et seq. authorize the Division of Workers' Compensation to request that the Applicant supply the Division with his or her Social Security Number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

DIVISION OF WORKERS' COMPENSATION

State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, New Jersey 08625-0381 WC-368supp r. 8/26/2015	**APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD** **SUPPLEMENTAL PAGE**	Case No.: _____ Vicinage: _____

ADDITIONAL CARRIERS

NAME:	NAME:
ADDRESS:	ADDRESS:
CARRIER CLAIM NUMBER:	CARRIER CLAIM NUMBER:
PERIOD OF COVERAGE:: FROM: TO:	PERIOD OF COVERAGE:: FROM: TO:

GUARDIAN OR REPRESENTATIVE

NAME:
ADDRESS:
RELATIONSHIP TO PETITIONER:

INDIVIDUAL CORPORATE OFFICERS/PARTNERS/LLC MEMBERS

NAME:	NAME:
ADDRESS:	ADDRESS: