State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

WC-369 r. 6/17/2015

ANSWER TO APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD

☐ **ORIGINAL ANSWER** ☐ **AMENDED ANSWER**

Case No.: _____

Vicinage: _____

PETITIONER

SOCIAL SECURITY OR IDENTIFICATION NUMBER:

NAME:

ADDRESS:

VS

RESPONDENT

NAME:

ADDRESS:

CORRECT NAME OF RESPONDENT IF INCORRECT ON CLAIM PETITION:

ATTORNEY FOR RESPONDENT

NAME:

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

INSURANCE CARRIER or SELF-INSURED ENTITY

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

THIRD PARTY ADMINISTRATOR

NAME:

ADDRESS:

TPA CLAIM NUMBER:

TO THE DIVISION OF WORKERS' COMPENSATION:

Respondent, in answer to the Application for Review or Modification, respectfully states:

Permanent Disability for prior award was paid from:

_____ to _____ for a total of _____ weeks, _____ days at $ _____ per week, totaling $ _____.

Temporary Benefits paid subsequent to satisfaction of prior award:

_____ to _____ for a total of _____ weeks, _____ days at $ _____ per week, totaling $ _____.

Medical Benefits paid subsequent to satisfaction of prior award:

_____ to _____, totaling $ _____.

The date of the last compensation payment was _____. The date of the last authorized treatment was _____.

The factual, legal and medical reasons for denying the application are as follows:

☐ **See Attached For Additional Information**

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

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

_____ _____

Attorney for Respondent **Date**