+Filed Date Stamp Here

PETITION FOR BENEFIT DETERMINATION
Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
PBD.CourtClerk@tn.gov
800-332-2667

Applies to injuries on or after July 1, 2014

(For injuries before July 1, 2014, please use a Request for Mediation)

For BWC Use Only

Docket No._____
State File No._____
RFA No._____
Date of Injury_____

Prior PBD Filed: ☐Yes ☐No
Assigned Judge_____

General Information

The Petition for Benefit Determination (PBD) is the form to file with the Bureau of Workers' Compensation to begin the dispute resolution process. The legal process for a workers' compensation claim begins with this filing.

Please see page 5 Helpful Tips and Information before completing this form. Call: 800-332-2667 or click here for additional help. Information about benefits, laws, and procedures is available at www.tn.gov/workerscomp.

If you fail to timely file this form with the Court Clerk, you may be denied benefits. This form must be filed within one year after the accident resulting in injury; one year from the last authorized medical treatment; or one year from the employer's last compensation payment to or on behalf of the employee, whichever is later.

Section A: Identify the people and the companies involved.

Employee Name _____ Date of Injury_____

SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Employee Attorney _____BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer(s) _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company: _____

Third Party Administrator: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Ins. Claim#_____

The Subsequent Injury Fund (SIF) may provide benefits to qualified employees who have a prior permanent physical disability and who become permanently and totally disabled by a later work injury. To preserve a claim against the SIF, Employee must submit this form via fax to 615-741-4169, email to WC.SIFLegal@tn.gov or mail to: SIF Director, Legal Section, 220 French Landing Drive, 3B, Nashville, TN 37243.

Is the Employee seeking recovery from the Subsequent Injury Fund? ☐YES ☐NO

SIF Attorney Name (If known): _____

Section B: Provide details about the work injury. (Attach additional sheets if necessary.)

The date of injury is: _____.

The injured body part(s) is (are): _____.

The place where the injury happened is: _____.

The witnesses to the injury are: _____.

The injury occurred while the employee was performing the following work activities: _____

_____

_____

_____

The injury was caused by: _____

_____

_____

Employee reported the injury to_____ on _____.
Insert Name. Insert Date.

Section C: Identify the problem you are having with the workers' compensation claim.

I, _____, have the following problem: (Attach additional sheets if necessary.)
Insert name.

_____

_____

_____

_____

Section D: Identify the workers' compensation issues that apply to the claim. (Select all that apply.)

Medical Benefits Please include medical records showing the treatment received for the work injury.

- ☐ Employee received a list of 3 doctors on _____ (Date) and selected _____ (Insert Doctor or Clinic Name).
- ☐ Employee has not received a list of 3 doctors.
- ☐ Employee has not received medical care from Employer or the insurance company.
- ☐ Employee has not received medical care as required by a court order. (Provide court order.)
- ☐ Employee was denied medical care after receiving it.
- ☐ Employee has not received medical care ordered by the doctor.
- ☐ Employee sought medical care from a physician who was not on the list provided by employer.

Temporary Disability Benefits Please include wage records and doctor notes taking you off work or assigned work restrictions.

- ☐ Doctor _____ (Insert Name) took employee off work and/or assigned restrictions of:

  _____
- ☐ Employee has missed the following days from work due to the injury:

  _____
- ☐ Employee has not been paid for missing work and/or believes he/she is owed more than received.
- ☐ Employee has been paid while missing work at the rate of $_____ per week.
- ☐ Parties do not agree on the amount of the temporary disability benefit.

Discovery If a PBD is already on file, it is not necessary to file another PBD for discovery.

- ☐ A subpoena is needed. (Include completed subpoena.) ☐ Other _____
- ☐ Written discovery responses have not been returned. (Include copies.)

Death Benefits

- ☐ The claim has been accepted. ☐ The claim was denied.
- ☐ There is a dependent spouse. ☐ There are dependents other than children & spouse.
- ☐ There are _____ (Number) dependent children. ☐ A child advocate needs to be appointed.

Permanent Disability Benefits Please provide the Final Medical Report (C30A) or most recent Physician's Report.

- ☐ A dispute exists regarding: ☐ Amount of Permanent Disability Benefit, ☐ Original Award, ☐ Resulting Award and/or Increased Benefits, ☐ Extraordinary Relief, ☐ Permanent Total Disability Benefits, and/or ☐ Other _____
- ☐ Employee reached maximum medical improvement on_____.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned an impairment rating of _____% to the body as a whole.
- ☐ Dr. _____ assigned permanent restrictions of: _____

  _____

Section E: Indicate Your Availability for Mediation:

Before a judge can decide a dispute about disability or medical benefits, the parties must participate in mediation. A mediator working for the state, without a stake in the outcome, will help the parties reach an agreement voluntarily. Most disputes are resolved without going before a judge.

Mediations must be scheduled by agreement between the parties. Please contact all parties and indicate the three (3) different agreed upon dates and times below. Please circle the desired time slot. If you do not have an attorney, you can call 800-332-2667 for help with selecting mediation dates.

_____	_____	_____
9:00 am or 1:00 pm	9:00 am or 1:00 pm	9:00 am or 1:00 pm

*The filing party must check one of the following:

- ☐ The above dates and times have been agreed upon by all parties.
- ☐ I am unable to coordinate dates with the other party; the dates above only show my availability.

Section F: Notice

A case can be lost because this form is not provided to the parties or their attorneys. Please indicate how you sent them a copy of this form. Click here for an example.

"Service sent to:" means the address, fax number, or email address used to send the form to the other party.

☐ **Employee**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employee's Atty**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Employer(s)' Atty(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **Carrier(s)**_____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

☐ **SIF's Atty** _____
Service by: ☐ By Hand ☐ Mail ☐ Facsimile ☐ Email
Service Sent to: _____

Section G: Certify the information contained in the Petition for Benefit Determination is correct.

I, _____, state that the information provided in this Petition for Benefit Determination is true and accurate to the best of my knowledge, information, and belief. Further, I certify a copy of the Petition for Benefit Determination **has been sent to the parties as described above.**

_____	_____	_____
Print Name	**Signature**	**Date**

Helpful Tips and Information

1. The best way to send in the form is by email to PBD.CourtClerk@tn.gov. Please make sure it is legible.

2. The Bureau will return a stamped copy of this form as proof the form was received within five days of receipt. If you do not receive a stamped copy, please contact the office designated for the employee's location listed on page 6.

3. Please fully complete this form. Missing information slows our ability to help you. You can get help to complete the form by calling 1-800-332-2667.

4. Please try to contact the other party to complete Section E. This speeds up our ability to help you.

5. A mediator helps the parties understand the problem and find solutions that work for everyone. The mediator does not work for the injured worker and is not a replacement for an attorney.

6. Please quickly submit your information. This increases your chance for success. Medical records are often provided too late, delaying disability payments and medical care.

7. Talk to your doctor and obtain medical records as soon as possible.

8. All medical records in your possession are required to be shared with the opposing party. This must be done within 15 days of submitting this form. This applies to all medical records that are relevant to your claim.

9. The injured worker has to prove he/she is owed the requested benefits.

10. If you are owed money because you cannot work, you must submit medical records. Doctors document when a patient cannot work or cannot perform certain work during specific periods. Please submit those records with this form.

11. If you have unpaid medical bills, please provide copies of them. Also send the medical records related to the bills.

12. If you are owed mileage, certain details are necessary. Please tell us how far you drove, the day you drove, and the name of the doctor you saw. Also send the medical record from that visit.

13. A copy of this form must be sent to all parties or their attorneys. Section F is required to prove you sent a copy to all the parties. The fax number, mailing address, or email address you used must be listed.

14. You must sign and date this form. If Section G has not been completed, the form will be returned. Your case will not be assigned for mediation.

For more information about workers' compensation benefits or how to complete this form, please visit our website at http://www.tn.gov/workforce/section/injuries-at-work or call 1-800-332-2667.

Please return the completed form to the office in the region of the Employee's home address per the map below.

Chattanooga
TN Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, TN 37402
Fax: 423-634-3115
Email: PBD.CourtClerk@tn.gov

Cookeville
TN Bureau of Workers' Compensation
444 – A Neal Street
Cookeville, TN 38501-027
Fax: 931-520-4316
Email: PBD.CourtClerk@tn.gov

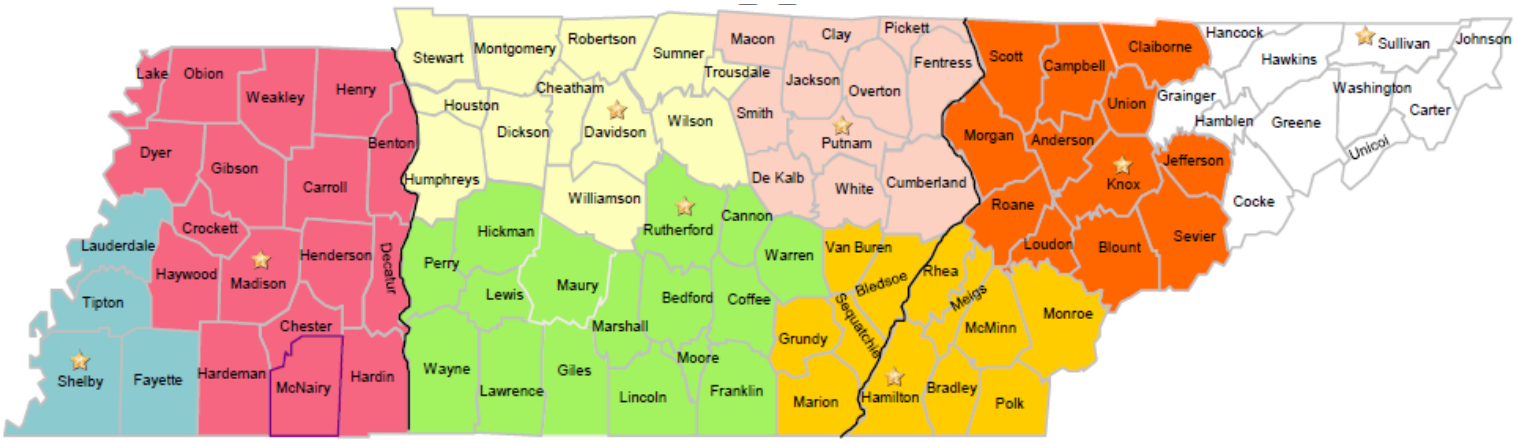
Jackson
TN Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6985
Fax: 731-265-7022
Email: PBD.CourtClerk@tn.gov

Gray
TN Bureau of Workers' Compensation
5788 Bobby Hicks Highway
Gray, TN 37615-3190
Fax: 423-239-7844
Email: PBD.CourtClerk@tn.gov

Knoxville
TN Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172
Email: PBD.CourtClerk@tn.gov

Memphis
TN Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039
Email: PBD.CourtClerk@tn.gov

Murfreesboro
TN Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378
Email: PBD.CourtClerk@tn.gov

Nashville
TN Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243-1002
Fax: 615-253-1223
Email: PBD.CourtClerk@tn.gov

Workers' Comp Court Clerk
TN Bureau of Workers' Compensation
220 French Landing, 1-B
Nashville, TN 37243-1002
Fax 615-253-2480
Email: PBD.CourtClerk@tn.gov