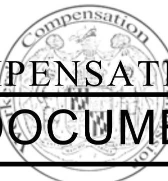

WORKERS' COMPENSATION COMMISSION

REQUEST FOR DOCUMENT CORRECTION

INSTRUCTIONS: This form is to be used by a party **ONLY** to notify the Commission that an undisputed factual error exists in a document that has been filed in a specific workers' compensation claim. The mistake may be an error in the document as originally submitted, or may be due to human or technological error. Any party identifying an error on a document in the Commission's files (paper or electronic) should complete this form and submit it to the Commission for consideration. The form should be submitted without a cover letter. For example, if all parties agree that the Date of Accident as originally submitted on a claim form is incorrect this form may be used to obtain a correction in the Commission's records. If, however, a factual dispute exists with respect to the Date of Accident and the party originally submitting the information believes it is factually accurate, the matter should not be categorized as a document correction. The dispute should be resolved at a hearing together with other matters upon which the parties do not agree.

THIS FORM MAY NOT BE USED TO ADD OR REMOVE A MEMBER OF THE BODY. The form ***Claim Amendment (C-3)*** must be used and includethe fully completed and executed Authoriation for Disclosure of Health Information (page 2).

An error has been identified in a claim document on file with the Workers' Compensation Commission as described below. This submission requests that corrective action be taken as soon as possible.

CLAIM NUMBER: **CLAIMANT NAME:**

DOCUMENT TYPE: **DOCUMENT DATE:**

ERROR DESCRIPTION:

CORRECTION REQUESTED:

REQUESTED BY:

CLAIMANT **CLAIMANT'S ATTY** **EMPLOYER/INSURER** **EMP/INS ATTY** **OTHER:**

FULL NAME (PRINTED) ______________________ **SIGNATURE** **DATE OF REQUEST**

Street Address **City** **State** **ZIP Code**

Telephone **Email Address**

10 East Baltimore Street · Baltimore, Maryland 21202-1641
410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us