WORKERS' COMPENSATION COMMISSION

INSURER'S TERMINATION OF MEDICAL BENEFITS

Pursuant to COMAR 14.09.06.04C, this form must be sent to the claimant. A copy must also be sent to the claimant's treating physician or health care provider, the Workers' Compensation Commission and the claimant's attorney.

WCC Claim Number: _____

Claimant: _____

Employer: _____

Insurer: _____

This is to advise that the insurer/employer will terminate payment for medical benefits under the above captioned claim effective: _____.

The claimant has the right to request a hearing before the Workers' Compensation Commission on the issue of this termination of medical benefits.

Health Care Provider: _____

Service or treatment being terminated:

Health Care Provider: _____

Service or treatment being terminated:

For further information, contact: _____ _____
Telephone Number

INSURER CERTIFICATION OF SERVICE

I hereby certify that on the ____ day of _____, 20__, a copy of this notice was sent to the Claimant, his/her counsel, the Maryland Workers' Compensation Commission and to the above named Health Care Provider(s).

Signature: _____ Date: _____

Printed Name: _____

Telephone Number: _____

Click Here to Clear the Form

10 East Baltimore Street · Baltimore, Maryland 21202-1641