

Filed Date Stamp Here



PETITION FOR BENEFIT DETERMINATION
 Tennessee Bureau of Workers' Compensation
 Court of Workers' Compensation Claims
www.tn.gov/workforce/section/injuries-at-work
 wc.ombudsman@tn.gov
 1-800-332-2667

Applies to injuries on or after July 1, 2014

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 to resolve disputes. The legal process for a workers' compensation claim begins with this filing. This form will serve as the basis for your claim. It is important that the form be filled out as completely and accurately as possible. For assistance with completing this form, please call: 1-800-332-2667.

Completion of this Form

Because this form outlines your claim, certain information is required. This is generally the who, what, when, where, why, and how of your case. You may not be able to fill in every blank. Do the best you can. However, remember that the more information provided the better. For assistance filling out this form you may view a [Completed PBD Example](#).

Time-Sensitive

In most cases, this form must be filed within one (1) year after the accident resulting in injury; one (1) year from the last authorized medical treatment; or one (1) year from the time the employer ceased to make payments of compensation to or on behalf of the employee, whichever is later. If you fail to timely file this form, you may be denied benefits.

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 _____

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

Medical Benefits

- Employee received a list of physicians on _____ and selected _____.
Date Insert Doctor or Clinic Name.
- Employee has not received a list of physicians.
- 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 has been denied medical care after receiving it. (Provide relevant medical records.)
- Employee has not received medical care ordered by the doctor. (Provide relevant medical records.)
- Employee sought medical care from a physician who was not on the list provided by employer. (Provide relevant medical records and bills.)

Temporary Disability Benefits [Provide wage statement or check stubs if you have them.]

- Doctor _____ took employee off work and/or assigned restrictions of:
Insert name.

- 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.

Death Benefits

- The claim has been accepted. The claim was denied.
- There is a dependent spouse. There are other dependents other than children.
- There are _____ dependent children. A guardian ad litem needs to be appointed.
Number

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 _____
- Interrogatories have not been returned. (Include interrogatories.)

Permanent Disability Benefits [Provide Final Medical Report (C30A) or most recent Physician's Report, if available.]

- Parties do not agree on the amount of the disability benefit.
- Employee is eligible for increased benefits because Employee did not return to work.
- 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 Mediation Preferences:

Before a dispute can be brought before a judge, the matter must go through mediation. Mediation is a process in which a mediator working for the state, without a stake in the outcome, works with the parties to resolve the dispute on a voluntary basis, otherwise known as settling the dispute. Most disputes are settled without going before a judge.

- I prefer to mediate over the phone. (If marked, skip to Section F.)
- I prefer to mediate in person. Was this Court-ordered? Yes No

In-Person mediations must be scheduled with agreement between the employee and the employer's representative. Please contact all parties and indicate the three (3) agreed upon dates and times below. Please circle desired time slot.

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

- By checking this box, I certify that the above dates and times have been agreed upon by all parties.
- I have made three (3) attempts to schedule mediation; however, the other party has not cooperated.

Section F: Notice

A copy of this form **must** be provided to the parties or their attorney. Indicate how you sent them a copy of this form. Service sent to: means the address, fax number, email address or company.

<input type="checkbox"/> Employee _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> Email Service Sent to: _____	<input type="checkbox"/> Employer(s) _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> Email Service Sent to: _____
<input type="checkbox"/> Employee's Atty _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> Email Service Sent to: _____	<input type="checkbox"/> Employer(s)' Atty(s) _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> Email Service Sent to: _____
<input type="checkbox"/> Carrier(s) _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> Email Service Sent to: _____	<input type="checkbox"/> SIF's Atty _____ Service by: <input type="checkbox"/> By Hand <input type="checkbox"/> Mail <input type="checkbox"/> Facsimile <input type="checkbox"/> 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

