District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Notice of Controversion
Memo of Denial of Workers' Compensation

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

Date of Accident: _____

Date First Report Received:_____

YOUR WORKERS' COMPENSATION BENEFITS ARE HEREBY DENIED BY EMPLOYER OR INSURER FOR REASON(S) INDICATED BELOW. IF YOU DISAGREE, YOU MAY APPPLY FOR A HEARING BY COMPLETING FORM NO. 20 (ON THE REVERSE).THE HEARING WILL BE SCHEDULED WITHIN 20 WORKING DAYS AFTER RECEIPT OF THIS NOTICE. IN THE INTERIM, IF YOU WISH TO PARTICIPATE IN AN INFORMAL CONFERENCE, YOU MAY CALL 202-671-1000 OR WRITE THE DIRECTOR AT THE ADDRESS ABOVE. YOU MAY BE REPRESENTED AT SUCH PROCEEDINGS IF YOU SO DESIRE, AND YOU WILL BE ADVISED IN WRITING OF THE PLACE, DATE AND TIME. IF YOU HAVE NOT ALREADY FILED AN EMPLOYEE'S CLAIM APPLICATION, FORM NO.7a DCWC, YOU MUST DO SO WITHIN ONE (1) YEAR OF THE DATE OF INJURY OR ONE (1) YEAR AGTER THE LAST PAYMENT OF COMPENSATION BENEFITS BY YOUR EMPLOYER.

REASONS

1. ❑ **No Employer- Employee Relations**
2. ❑ **No Casual Relationship to Employment**
3. ❑ **Improper Notice of Injury by Employee**
4. ❑ **Continuing Disability Contested**
5. ❑ **No Jurisdiction Under D.C. Law**
6. ❑ **Other**

Explanation:_____
_____
_____
_____
_____
_____

Authorized Representative _____

❑ **INITIAL DENIAL** ❑ **SUBSEQUENT DENIAL**