Print Reset

CARRIER'S RESPONSE

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

Social Security Number	Date of Birth	Employee Name		
Employee Address (Street No. and Name)		Employee City	State	Zip Code
Date(s) of Injury		Insurance Company/TPA Claim Number		
Employer		Insurance Company or TPA (If self-insured)		
Employer Address (Street No. and Name)		Insurance Company Address (Street No. and Name)		
City	State / Zip Code	City	State	Zip Code
Federal ID Number		NAIC or Self-Insurance Number		

1. Do you dispute that the injury or disability is work related? ☐ Yes ☐ No

2. Do you dispute that the claimant is disabled? ☐ Yes ☐ No

3. List reasons supporting your position in the space provided.

4. Have you had the claimant medically examined in connection with this claim? ☐ Yes ☐ No
   If yes, give name and address of individual who performed the examination.

5. **Do you certify that to the best of your knowledge all existing medical records of the carrier or employer contained in your file that are relevant to this claim have been furnished to the claimant and/or the claimant's attorney?** ☐ **Yes** ☐ **No**

Claims person/attorney to whom correspondence should be sent	Attorney ID Number (If applicable)
Claims office/attorney address	Telephone No. (Include area code)
Preparer Signature	Date

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Authority: Workers' Disability Compensation Act, Section 418.222
Completion: This form is to be submitted by the carrier within thirty (30) days after the carrier's receipt of a completed Application for Mediation or Hearing.
Penalty: Failure to complete shall prohibit that party from proceeding.