**[ ]**

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| **Instructions:** Please complete all applicable fields. Send the completed form to ra-benwc@pa.gov, COPANotices@pnat.com, and insvhb@pnat.com. You may add information to the subject line, and you may include an email introduction, but it is not required since all of the information should be contained on this form. |
| **Claim Information:** |
| Claimant | Inservco Claim Number | Adjuster |
|       |       |       |
| Agency Name | Date of Injury |
|       |       |
| **Medical Only to Lost Time:** |
| Last Day Worked  | First Day of Absence  |
|       |       |
| **Special Benefit Changes:**  |
| Effective Date:       |
| [ ]  No longer on special benefits [ ]  Benefits denied [ ]  Other       | Comments:       |
| **Recurrence:** |
| Date employee reported need for additional treatment  |
|       |
| Describe the event which caused the recurrence  |
|       |
| Date of Absence (Lost Time Only) |
|       |
| Other Comments |
|       |
| **For Inservco Use Only:** |
| Inservco Reviewer | Date |  |
|       |       |  |
| Transferred to LT  | Date |  |
|       |       |  |