Notice of Denial of Benefits

State Form 53914 (R3 /)

** Please see reverse side for Instructions **

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

Date of Injury *(month, day, year)*	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address *(number and street, city, state, and ZIP code)*	Address *(number and street, city, state, and ZIP code)*
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address *(number and street, city, state, and ZIP code)*	
E-mail Address	

NOTICE OF DENIAL

☐ Full Denial Full Denial Effective Date:	☐ Partial Denial Partial Denial Effective Date:
Reason(s) For Denial:	Reason(s) For Denial:

Explanation:

NOTICE TO EMPLOYEES

By filing this form, your employer or its insurance carrier has indicated to the Indiana Worker's Compensation Board that it has cause to deny worker's compensation benefits for your reported injury. You may or may not agree with this denial of benefits.

If you disagree with the denial of benefits, you should discuss the reason for denial with your employer or employer's insurance carrier. If, after having this discussion, you are not satisfied that benefits were properly denied, you may contact an attorney for legal advice, or contact an ombudsman at the Indiana Worker's Compensation Board for information at (317) 233-3009. Additional information can also be found at www.in.gov/wcb.

EMPLOYER CERTIFICATION

Employer must sign below to certify service of this notice.

Signature of Employer	*Date (month, day, year)*
Printed Name	*By (check one):* ☐ US Mail ☐ Electronic Service

INSTRUCTIONS FOR FULL OR PARTIAL DENIALS

FULL DENIALS:
You may select up to five (5) different reasons listed below explaining why the claim is being denied. Please put the code(s) inside the "Full Denial" box provided followed by a denial reason narrative in the explanation field.

FULL DENIAL REASON CODES:

No Compensable Accident/Not in Course and Scope of Employment

1A - Coming and Going
1B - Horseplay
1C - Willful Intent to Injure Oneself
1D - Not Statutory Definition of Accident
1E - Deviation From Employment
1F - Recreational/Social Activity
1H - Subsequent Intervening Accident

No Causal Relationship

2A - Idiopathic Condition
2B - Pre-existing Condition
2C - Stress Non-Work Related
2D - No Medical Evidence of Injury
2E - No Injury Per Statutory Definition
2F - Accident Not Major Contributing Cause of Injury

No Coverage

3A - No Employee/Employer Relationship
3B - Independent Contractor
3C - Not Statutory Definition of Employee
3D - No Jurisdiction
3E - No Policy in Effect On Date of Accident
3F - Statute of Limitation Expired
3G - Statutory Exemptions (Sole Proprietor, Corporate Officer, etc)
3I - Employee Not Reported to PEO

Substance Use/Abuse

4A - Injury Primarily Occasioned by Intoxication or Use of Any Drug

Other (Not Elsewhere Classified)

5A - Failure To Report Accident Timely
5C - Misrepresentation

PARTIAL DENIALS:
Please select one (1) of the reasons below to help explain which aspect(s) of the claim is being denied. Please put the code inside the "Partial Denial" box provided followed by a denial reason narrative in the explanation field.

PARTIAL DENIAL REASON CODES:

A - Denying Indemnity in Whole, Not Medical
B - Denying Indemnity in Part, Not Medical
C - Denying Medical in Whole, Not Indemnity
D - Denying Medical in Part, Not Indemnity
E - Denying Indemnity in Whole, Medical in Part
F - Denying Medical in Whole, Indemnity in Part
G - Denying Both Indemnity & Medical in Part