



CHANGE IN CONDITION CLAIMS RESPONSE FORM

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

www.workcomp.virginia.gov

JCN Number:

Date of accident:

Style of case:

Response of: Employer Insurer Other Claim for Benefits filed on (date):

1. The claim is accepted.

- a. Payment was made on (date):
- b. Agreement forms were forwarded to: _____ on (date):
- c. Counsel will be submitting a Stipulated Order.

2. The claim is accepted in part and denied in part.

a. The accepted portions of the claim are:

i.

1. Payment was made on (date):
2. Agreement forms were forwarded to: _____ on (date):
3. Counsel will be submitting a Stipulated Order.

ii.

1. Payment was made on (date):
2. Agreement forms were forwarded to _____ on (date):
3. Counsel will be submitting a Stipulated Order.

b. The denied portions of the claim are:

i.

ii.

3. The claim is denied.

a. Denial Reason:

b. This party does does not consent to Issue Mediation.

Signature:

**By checking this box and typing my name above, I am electronically signing this form.*