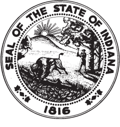

NOTICE OF SUSPENSION OF MEDICAL BENEFITS

State Form 54217 (3-10)

INDIANA WORKER'S COMPENSATION BOARD
402 W Washington Street, Room W196
Indianapolis, IN 46204

* PRIVACY NOTICE: This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

Pursuant to IC 22-3-3-4(c) or 22-3-3-6(a), NOTICE is hereby given that the employer intends to suspend all benefits for a compensable injury under the Indiana Worker's Compensation Act because of employee's refusal to accept medical services and/or supplies prescribed by the authorized treating physician and provided by employer.

EMPLOYER AND CARRIER INFORMATION	
Name of employer	Federal Identification number
Address (*number and street, city, state, and ZIP code*)	
Name of Insurance Carrier / Third Party Administrator	Claim number of insurer
Address (*number and street, city, state, and ZIP code*)	

ADJUSTER / ATTORNEY INFORMATION		
Name of adjuster / attorney *(typed or printed)*		
Address (*number and street, city, state, and ZIP code*)		
Telephone number ( )	Fax number ( )	E-mail address
Signature of adjuster / attorney		Date signed *(month, day, year)*

EMPLOYEE INFORMATION

According to IC 22-3-3-4(c) or 22-3-3-6(a), injured workers shall not receive temporary total or partial disability payments and/or permanent partial impairment payments, reimbursement for unauthorized medical care, nor are they entitled to have a case heard, until they agree to follow the treatment plan set by the treating physician.

Name of employee	Social Security number *
Address (*number and street, city, state, and ZIP code*)	Telephone number ( )
Date suspension initiated *(month, day, year)*	Date of injury *(month, day, year)*
Reason medical benefits are being suspended:	
Actions required to have medical benefits reinstated::	
Signature of employee acknowledging receipt:	Date signed *(month, day, year)*