CHANGE IN CONDITION CLAIM RESPONSE FORM

Virginia Workers' Compensation Commission
333 E. Franklin St.
Richmond, Virginia 23219
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. ☐
   d. Other:

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