Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
http://www.tn.gov/workforce/section/injuries-at-work

REQUEST FOR MEDICATION

(For injuries prior to 7/1/2014 only)
This form replaces the Request for Assistance (C40A), the Request for Benefit Review Conference (C40B) and the Certificate of Readiness (C40R).

This request is for:

☐ Lost Wage Benefits ☐ Medical Benefits ☐ Discovery
☐ Penalty (For Late or Non-Payment of wages) ☐ Lifetime Medical Coverage

OR

☐ A Benefit Review Conference:

☐ To keep the statute of limitations from running or,

☐ For mediation--I am ready to proceed to mediation in a Benefit Review Conference.

Date of MMI _____ Impairment Rating Assigned _____

If applicable, the Subsequent Injury Fund Attorney is _____ & he/she has been notified.

The parties have discussed possible dates for conducting the mediation and <u>all parties or their representatives have agreed upon the three dates and times listed below.</u> Please provide dates and circle the desired time slots.

_____	_____	_____	_____	_____
9:00am or 1:00 pm	9:00am or 1:00 pm	9:00am or 1:00 pm	Signature of Requesting Party	Signature of Opposing Party

Please give a brief description of the disputed issues: _____

_____

Date of Injury _____ TN County of Injury (Name state if injury not in TN)_____

Employee Name _____ SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Employee Attorney _____BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company or TPA: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

REQUESTING PARTY

I hereby request the Tennessee Bureau of Workers' Compensation to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Bureau to contact any person who has information regarding that injury.

_____ _____ _____

Printed name **Signature** **Date**

Please return the completed form to the office below that is closest to the Employee's home address or
@ email:**WC.Ombudsman@tn.gov**

Chattanooga
Tennessee Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, Tennessee 37402
Fax: 423-634-3115

Cookeville
Tennessee Bureau of Workers' Compensation
P.O. Box 678
Cookeville, Tennessee 38503-0678
Fax: 931-520-4316

Gray
Tennessee Bureau of Workers' Compensation
5788 Bobby Hicks Hwy.
Gray, TN 37615
Fax: 423-239-7844

Jackson
Tennessee Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6920
Fax: 731-265-7022

Knoxville
Tennessee Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172

Memphis
Tennessee Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039

Murfreesboro
Tennessee Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378

Nashville
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, Tennessee 37243-1002
Fax: 615-253-1223