

CARRIER'S RESPONSE

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P O Box 30016, Lansing, MI 48909

Social Security Number	Date of Birth	Employee Name			
Employee Address (Street No. and Name)		Employee City	State	Zip Code	
Date(s) of Injury		Insurance Company/TPA Claim Number			
Employer		Insurance Company or TPA (if self-insured)			
Address (Street No. and Name)		Address (Street No. and Name)			
City	State	Zip Code	City	State	Zip Code
Federal ID Number		NAIC or Self-Insurance Number			
1. Do you dispute that the injury or disability is work-related?		Yes	No		
2. Do you dispute that the claimant is disabled?		Yes	No		
3. List reasons supporting your position in the space provided.					
4. Have you had the claimant medically examined in connection with this claim? If yes, give name and address of individual who performed the examination.		Yes	No		
5. Do you certify that to the best of your knowledge all existing medical records of the carrier or employer contained in your file that are relevant to this claim have been furnished to the claimant and/or the claimant's attorney? Yes No					
Claims person/attorney to whom correspondence should be sent			Attorney ID Number (if applicable)		
Claims office/attorney address			Telephone No. (Include area code)		
Preparer Signature				Date	

AUTHORITY: Workers' Disability Compensation Act, Section 418.222
 COMPLETION: This form is to be submitted by the carrier within thirty (30) days after the carrier's receipt of a completed Application for Mediation or Hearing
 PENALTY: Failure to complete shall prohibit that party from proceeding.

Form #

BWC-251

Form Name:

Carrier's Response

When Required:

This form is to be submitted by the carrier within thirty (30) days after the carrier's receipt of a completed Application for Mediation or Hearing.

Required Fields:

All applicable fields must be completed.

- ✓ Forms will be returned if the Social Security Number, Employee, Employer, and Insurance Company/TPA (if self-insured) fields are not completed.

Instructions:

Completing the Form:

- ✓ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✓ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✓ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✓ Press Tab to accept the field change and go to the next field, or Press Shift + Tab to accept the field change and go to the previous field.
- ✓ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✓ To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.
- ✓ To print the completed form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-inform, please send them to bwdcinfo@cis.state.mi.us. Please include the keyword "Fill-In Form 251" with your comments.

How to Submit This Form:

- ✓ Print the completed form
- ✓ Sign and make copies to be distributed to the claimant or his/her attorney as well as all other parties listed on the hearing notice.
 - ❖ Keep a copy for your records
 - ❖ Mail the original signed Form 251 to:

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P O Box 30016
Lansing MI 48909**