NOTICE OF DISPUTE

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
4. Employee Address (Street No. and Name)		5. City	6. State	7. ZIP Code
8. Employer Name				9. Federal ID No.
10. Employer Street Address		11. City	12. State	13. ZIP Code
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. ZIP Code
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	19. ZIP Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)

23. Reason for Dispute

A. _____ Injury not work related

B. _____ Medical treatment not related to injury

C. _____ Further investigation required (please specify below)

D. _____ Additional information required from employee (please specify below)

E. _____ Vocational rehabilitation dispute only (please specify below)

F. _____ Other (please specify below)

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, R408.33 (1)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer's Name (Please print)	25. Signature	26. Telephone No.	27. Date

NOTICE TO EMPLOYEE

By filing this form, your employer or its workers' compensation insurance company has indicated to the Workers' Compensation Agency that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

If you feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Workers' Compensation Agency at our toll-free number of 1-888-396-5041. Additional information may also be found on our website at **www.michigan.gov/wca**.

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

WC-107 – Notice of Dispute Instructions

A carrier shall notify the Workers' Compensation Agency on or before the fourteenth day after the employer has notice or knowledge of the alleged injury or death, in all cases where the right of the injured or dependent to compensation is disputed.

Required fields: All applicable fields must be completed.

- ✓ Forms will be returned if fields 1-3, 8, and 14 are not completed.
- ✓ You will receive a letter if fields 4 and 23 are not completed.
- ✓ Do not use "Other" as reason for dispute unless absolutely necessary.

Send a copy of the completed signed form to the employee.

Mail the original signed form to:

Workers' Compensation Agency
PO Box 30016
Lansing, MI 48909