Instructions Print Reset

CLAIM/CROSS-CLAIM FOR REVIEW

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016
Lansing, Michigan 48909
Fax: (517) 284-8920

Please check one: ☐ **Claim for Review** ☐ **Cross-Claim for Review**

INSTRUCTIONS: SEE REVERSE SIDE

1. Social Security Number	2. Employee Name (Last, First, Middle Initial)		
3. Employee Street Address	4. City	5. State	6. ZIP Code

7. Party Filing this Appeal
☐ Plaintiff ☐ Carrier or Self-Insured ☐ Employer (If Uninsured) ☐ Other (Specify)

8. Employer Name	9. Federal ID Number
10. Carrier or Self-Insured Name	11. NAIC or Self-Insured Number

12. Order Number

A COPY OF THE ORDER BEING APPEALED MUST BE ATTACHED

13. Type of Order Being Appealed (Check Only One)

A. ☐ Decision on Merits	D. ☐ Interlocutory Decision	G. ☐ Vocational Rehabilitation Order
B. ☐ Dismissal of Petition	E. ☐ Redemption Order	H. ☐ Attorney Fees
C. ☐ Director's Order	F. ☐ Advance Payment Order	I. ☐ Other

14. Basis of Claim. This application for review of claim is based on the following grounds:

15. Transcript Required? ☐ Yes ☐ No	If no, reason:

16. Number of Transcript(s)	Date Transcript(s) Ordered	Hearing Dates:

17. Proof of Service Attached? ☐ Yes ☐ No	If no, reason:

I8. If representing yourself, please complete this section.

Signature	Telephone Number	Date Signed

19. Legal counsel, if obtained, must complete this section.

Signature	Attorney ID Number **P -**	Date Signed

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act 418.101 et seq. Completion: Voluntary Penalty: Order Stands

INSTRUCTIONS FOR COMPLETING WC-262

A Claim for Review must be filed within **30 days** of the mailing date of the magistrate's order, or the order stands as final. However, all redemption, advance payment, attorney fee, and director's orders must be filed within **15 days**, or the order stands as final.

The completed form should be mailed OR faxed (do not submit using both methods) using the contact information on the front of this form along with a copy of the order being appealed. A separate Claim for Review must be filed for each order being appealed. If you require more space than is provided on this form, use a separate sheet of paper to provide the additional information and include the employee's name and social security number. Please note on the application that the required information is on an attached sheet.

1.	***Social Security Number***	Enter the social security number of the injured employee.
2.	***Name of Employee***	Enter the complete name of the injured employee.
3-6.	***Employee Address***	Enter the street address, city, state and ZIP code of the injured employee.
7.	***Party filing this appeal***	Indicate which party is filing this appeal. If other, please specify. Only one box should be checked.
8.	***Employer Name***	Enter the name of the employer involved in the appeal.
9.	***Federal ID Number***	Enter the FEIN (Federal Employer ID Number) of the employer listed in Item 8, if known.
10.	***Carrier or Self-Insured Name***	Enter the name of the insurance carrier or self-insured employer involved in this appeal.
11.	***NAIC or Self-Insured Number***	Enter the NAIC or self-insured number of the carrier or self-insured listed in Item 10, if known.
12.	***Order Number***	Enter the 13-digit number located at the top of the order which is being appealed. The first six digits represent the mailed date.
13.	***Type of Order Being Appealed***	Indicate which type of order is being appealed. If Box A, B, C, D or G is checked, any future filings on this appeal must be sent to the Workers' Disability Compensation Appeals Commission, PO Box 30468, Lansing, MI 48909. Fax Number: 517-284-5391.
14.	***Basis of Claim***	Indicate the grounds upon which this Claim for Review is based.
15.	***Transcript Required/Reason***	Indicate whether transcript(s) are required. If no, specify the reason.
16.	***Number of Transcript(s)/ Date Transcript(s) Ordered***	Indicate the number of transcript(s) and the date they were ordered (if required). Also indicate the hearing date(s) in which testimony was taken.
17.	***Proof of Service Attached***	Indicate whether proof of service is attached. If not attached, specify the reason.
18.	***Applicant Signature***	If representing yourself, please sign and date this form and provide telephone number.
19.	***Attorney Signature***	If legal counsel is obtained, the attorney must sign and date this form and provide attorney ID number.

Go Back to Form