

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REQUEST TO BECOME A PARTY AT INTEREST PURSUANT to O.C.G.A §34-9-206

Instructions: Pursuant to O.C.G.A §34-9-206, any group insurance company or other health care provider who has made payments on the employee's behalf or provided medical services and who wishes to be named a party at interest to obtain reimbursement for those expenses which have been paid, shall file this form, including supporting documentation, with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

|                 |                    |                     |      |                         |                |
|-----------------|--------------------|---------------------|------|-------------------------|----------------|
| Board Claim No. | Employee Last Name | Employee First Name | M.I. | SSN or Board Tracking # | Date of Injury |
|-----------------|--------------------|---------------------|------|-------------------------|----------------|

| A. IDENTIFYING INFORMATION |                  |  |                                  |          |          |
|----------------------------|------------------|--|----------------------------------|----------|----------|
| <b>EMPLOYEE</b>            | County of Injury |  | Address                          |          |          |
|                            | Employee E-mail  |  | City                             | State    | Zip Code |
| <b>EMPLOYER</b>            | Name             |  | <b>INSURER/<br/>SELF-INSURER</b> | Name     |          |
|                            | Address          |  | <b>CLAIMS OFFICE</b>             | Name     |          |
| City                       |                  |  | State                            | Zip Code |          |
| Employer E-mail            |                  |  | Claims E-mail                    |          |          |

| B. NOTICE  |       |          |        |
|--|-------|----------|--------|
| Notice is hereby given that: _____<br>(Print Name Group Insurance Company or Healthcare Provider)  |       |          |        |
| Address  |       | Phone    |        |
| City   | State | Zip Code | E-mail |
| has made payments or provided medical services in the amount of \$ _____ on the employee's behalf for medical treatment, and desires to be made a party at interest in this claim in order to demonstrate that the employer/workers' compensation carrier are responsible for reimbursement for funds so expended, should liability be established under Title 34-9. |       |          |        |

| C. CERTIFICATION  |           |               |
|---|-----------|---------------|
| <input type="checkbox"/> I hereby certify that I have sent a copy of this form to all parties and counsel in this claim, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 |           |               |
| Print Name Here   | Signature | Date          |
| Phone   | E-mail    | GA Bar number |

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.ga.gov>  
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).