WC-3 NOTICE TO CONTROVERT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO CONTROVERT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
0005	0043 0255	0044	0045	0042	0031

A. IDENTIFYING INFORMATION

EMPLOYEE	Phone Number: 0051	Address: 0046 0047		
Employee E-mail Address: N/A		City: 0048	State: 0049	Zip Code: 0050
EMPLOYER	Name: 0018			Phone Number: 0159
Address: 0019 0020				
City: 0021			State: 0022	Zip Code: 0023
Employer E-mail Address: N/A				
INSURER/ SELF-INSURER	Name: 0007 0006			Insurer/Self-Insurer File #: 0015
CLAIMS OFFICE	Name: 0188 0187			Phone Number: 0137
Address: 0010 0011				SBWC ID# (five digit no.): N/A
City: 0012		State: 0013	Zip Code: 0014	
Claims Office E-mail Address				

B.

0 1. This serves as notice, pursuant to O.C.G.A. §34-9-221, that the right to compensation in this claim is being controverted on the following specific grounds:

0002/04 0198 0197 0002/PD 0294-A

0 2. This is notice, pursuant to O.C.G.A. §34-9-200 and Board Rule 205(b), that the compensability of the following medical treatment / test is being controverted for the following specific reasons:

0002/PD 0294-D

0 3. If only part of the claim is being controverted, state the specific part of the claim and the reason(s) it is being controverted:

0002/PD 0294-B, E, F, G

C.

0 This is to certify that a copy of both sides of this notice has been sent to the employee / claimant(s), all counsel of record and any other person with a financial interest, as listed below:

Type or Print Name	Signature	Date

Phone Number	E-mail Address

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be given to the employee and any other person with a financial interest in the claim including, but not limited to the employer, medical care provider(s) and attorney(s).