TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

DWC Claim#

Carrier Claim#

EMPLOYER'S CONTEST OF COMPENSABILITY (DWC Form-004)

The employer has the right to contest the compensability of an employee's injury if the insurance carrier accepts liability for the payment of benefits. The employer may contest compensability of a claim after presenting the grounds for non-compensability to the carrier and giving the carrier the opportunity to contest compensability. [Texas Workers' Compensation Act §409.011]

1. Employee's Name (Last, First, M.I.)	**2. Social Security Number** (last four digits) XXX-XX-
3. Date of Injury (mm/dd/yyyy)	**4. Employer's Name** (Last, First, M.I.)
5. Employer's Mailing Address (Street or P.O. Box, City, State, Zip)	
6. Employer's Telephone No.	**7. Insurance Carrier**
8. Provide any relevant facts supporting the reason(s) for contesting compensability.	

Employer's Signature _____ **Date** _____

Title _____

TDI-DWC Date Stamp Here

If you have questions about this form, contact staff at your local TDI-DWC Field Office at 800-252-7031.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html