TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Claim Administration Contact Information

AUSTIN REPRESENTATIVE INFORMATION

1. Austin Representative's Name (First, Last)	**2. Austin Representative's Organization Name**
3. Austin Representative's Mailing Address (Street or P.O. Box, City, State, ZIP)	
4. Austin Representative's Phone Number ( )	**5. Austin Representative's Fax Number** ( )
6. Austin Representative's Email Address	

INSURANCE CARRIER

7. Insurance Carrier's Name	
8. Insurance Carrier's Federal Employer ID Number (FEIN)	**9. Insurance Carrier's Group Affiliation** (if applicable)
10. Insurance Carrier's Primary Mailing Address (Street or P.O. Box, City, State, ZIP)	
11. Insurance Carrier Contact Name (First, Last)	
12. Insurance Carrier Contact Phone Number ( )	**13. Insurance Carrier Contact Fax Number** ( )
14. Insurance Carrier Contact Email Address	

OPTION 1 – INSURANCE CARRIER CONTACT INFORMATION WEB ADDRESS

15. Effective Date	**16. Web Address URL**

OPTION 2 – Instead of an insurance carrier web address, complete applicable claim administration information.

CLAIM ADJUSTMENT

17. Business Name	**18. Effective Date**
19. Business Address (Street or P.O. Box, City, State, ZIP Code)	
20. Email Address	
21. Phone Number ( )	**22. Fax Number** ( )
23. Comments	

COVERAGE VERIFICATION

24. Business Name	**25. Effective Date**
26. Business Address (Street or P.O. Box, City, State, ZIP Code)	
27. Email Address	
28. Phone Number ( )	**29. Fax Number** ( )
30. Comments	

MEDICAL BILLING

31. Business Name	**32. Effective Date**
33. Business Address (Street or P.O. Box, City, State, ZIP Code)	
34. Email Address	
35. Phone Number ( )	**36. Fax Number ( )**
37. Comments	

PHARMACY BILLING

38. Business Name	**39. Effective Date**
40. Business Address (Street or P.O. Box, City, State, ZIP Code)	
41. Email Address	
42. Phone Number ( )	**43. Fax Number ( )**
44. Comments	

PREAUTHORIZATION

45. Business Name	**46. Effective Date**
47. Business Address (Street or P.O. Box, City, State, ZIP Code)	
48. Email Address	
49. Phone Number ( )	**50. Fax Number** ( )
51. Comments	

WORKERS' COMPENSATION HEALTH CARE NETWORK

52. Business Name	**53. Effective Date**
54. Business Address (Street or P.O. Box, City, State, ZIP Code)	
55. Email Address	
56. Phone Number ( )	**57. Fax Number** ( )
58. Comments	

AUSTIN REPRESENTATIVE AFFIRMATION

The undersigned Austin representative authorizes DWC to add or update claim administration contact information for the insurance carrier identified above. Through my signature below, I affirm my specific authority to execute this form on behalf of the insurance carrier.

59. Austin Representative Signature	For DWC Use Only
60. Austin Representative's Printed Name	
61. Date of Signature	

Frequently Asked Questions
Claim Administration Contact Information

Who must file this form?
Insurance carriers, including certified self-insurers, certified self-insurer groups, and governmental entities, must provide new or updated claim administration contact information through their Austin representative. Insurance carriers are required to provide claims adjustment, coverage verification (policy issuance and effective dates of policy), medical billing, pharmacy billing (if different from medical billing), and preauthorization contact information. 28 Texas Administrative Code Section 124.2.

Insurance carriers may provide this information with a single webpage created and maintained by the insurance carrier that contains the required information. If the webpage option is used, the page must contain the date on which it was last updated and an email address or other contact information to which a user may report problems or inaccuracies. Insurance carriers with multiple offices should use their primary location when filling out the "Insurance Carrier" section of the form.

When must I update claim administration contact information?
Insurance carriers are required to update the contact information or the webpage address within 10 working days after a change is made.

Do I have to fill in every field on the form each time I send it?
Yes. The contact information for each function must include mailing address, telephone number, fax number, and email address as appropriate. However, if Option 1 is filled in, boxes 17 through 58 may be left blank. If Option 2 is selected, boxes 15 and 16 may be left blank.

Where do I file the DWC Form-121?
Send the form to DWC by fax at (512) 804-4146 or by mail to:

Texas Department of Insurance
Division of Workers' Compensation
PO Box 12050
Austin, Texas 78711

What does DWC do?
DWC will update the claim administration contact information for the insurance carrier in TXCOMP, DWC's automated system where the public can find the information. See the TDI website and select the "TXCOMP" link and choose "Locate Insurance Carrier." After selecting an insurance carrier, click "View Claim Administration Contact."

Need more information?
Call 512-804-4345, Monday to Friday, 8 a.m. to 5 p.m. Central time.

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.