Texas Department Of Insurance
Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-93
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#

Carrier Claim#

Send the completed form to the TDI-DWC field office handling the 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.	

TDI-DWC Date Stamp Here

Employer's Signature _____ **Date** _____

Title _____

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

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.