

FORM PT-01

Petition for a Modification of Order [A.S.C.A. §32.0654]

Instructions: Pursuant to A.S.C.A. §32.0654, an interested party may file a petition with the Commissioner to modify an order on the ground of a change in condition, or a mistake in the determination of fact by the Commission. A modification may result to a new compensation order which may terminate, continue, reinstate, increase or decrease such compensation or award. This petition form must be filed at any time prior to one year after the date of the last payment of compensation (whether or not a compensation order has been issued), or at any time prior to one year after the rejection of a claim.

1. Date of this Petition:	2. Name of Person Filing Petition: (First, Middle, Last)	
3. Indicate which of following represents the person filing this request: <input type="checkbox"/> Employee / Petitioner <input type="checkbox"/> Employer <input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Dependent		4. WCC Case No.:
5. Status of Claim: <input type="checkbox"/> Approved / Settled <input type="checkbox"/> Rejected / Denied	6. Date of Last Payment Made:	Date of Claim Rejection:
7. Specify compensation benefit(s) being petitioned for modification:		
<input type="checkbox"/> Death Benefits <input type="checkbox"/> Temporary Total Disability (TTD) <input type="checkbox"/> Temporary Loss in Wage-Earning (TPD)	<input type="checkbox"/> Permanent Impairment Disability <input type="checkbox"/> Disfigurement <input type="checkbox"/> Medical Benefits	
8. Describe and clarify all factual evidence to justify a modification, termination, or suspension of an order before the Commissioner. All supporting documentations to support such facts must be furnished and submitted together with this form.		
9. Contact Information: Mailing Address:	Telephone Mobile No.:	
	Email Address (if any):	
10. Authorization: (Sign Here): _____ Authorize Signature	FILED *** AUTHORIZED OWCC PERSONNEL ONLY ***	
		