COMPLAINT FOR PENALTIES 39-A §205(4)

STATE OF MAINE
WORKERS' COMPENSATION BOARD
ABUSE INVESTIGATION UNIT
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER

[CHECK ONE]:

☐ HEALTH CARE PROVIDER ☐ EMPLOYEE

NAME: ____________________

STREET/P.O. BOX: ____________________

CITY, STATE, ZIP: ____________________

TELEPHONE NUMBER: ____________________

BOARD FILE NUMBER (if known): ____________________

RESPONDENT - INSURER

NAME: ____________________

STREET/P.O. BOX: ____________________

CITY, STATE, ZIP: ____________________

NOTICE

A party is not required to file a written response to this petition under 39-A M.R.S.A. §307(3).

1. On ____________________ (MONTH DAY YEAR), ____________________ (EMPLOYEE NAME) sustained a work-related injury while working for ____________________ (EMPLOYER NAME).

2. **[CHECK ONE]:**

   ☐ On ____________________ (MONTH DAY YEAR), the employee sent the employer/insurer copies of bills paid for by the employee for medical or health care services related to the injury.

   - OR -

   ☐ On ____________________ (MONTH DAY YEAR), the health care provider sent the employer/insurer copies of bills for medical or health care services related to the work-related injury.

3. The bills were sent by certified mail. **[YOU MUST ATTACH PROOF OF SERVICE BY CERTIFIED MAIL.]**

4. There is no ongoing dispute regarding the claim and the insurer/employer has failed to pay the medical bills submitted to it within thirty (30) days after receiving notice, by certified mail, of nonpayment of the bills.

WHEREFORE, I request such penalties as I may be entitled pursuant to Title 39-A §205(4).

____
SIGNATURE OF PETITIONER

DATED: ____________________
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested**, to each other party named in the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

____
NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

____
STREET/P.O. BOX

____
CITY, STATE, ZIP

____
TELEPHONE NUMBER

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.