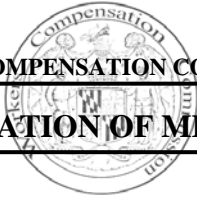


WORKERS' COMPENSATION COMMISSION



**INSURER'S TERMINATION OF MEDICAL BENEFITS**

Pursuant to COMAR 14.09.06.04C, this form must be sent to the claimant. A copy must also be sent to the claimant's treating physician or health care provider, the Workers' Compensation Commission and the claimant's attorney.

**WCC Claim Number:**

**Claimant:**

**Employer:**

**Insurer:**

**This is to advise that the insurer/employer will terminate payment for medical benefits under the above captioned claim effective:** .

**The claimant has the right to request a hearing before the Workers' Compensation Commission on the issue of this termination of medical benefits.**

Health Care Provider:

Service or treatment being terminated:

Health Care Provider:

Service or treatment being terminated:

For further information, contact:

Telephone Number

**INSURER CERTIFICATION OF SERVICE**

I hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, a copy of this notice was sent to the Claimant, his/her counsel, the Maryland Workers' Compensation Commission and to the above named Health Care Provider(s).

Signature: \_\_\_\_\_

Date:

Printed Name:

Telephone Number: