Send to:
TEXAS WORKERS' COMPENSATION COMMISSION
4000 South IH-35 Southfield Building MS-92B
Austin, Texas 78704

SUBMIT A SEPARATE TWCC-153 FOR EACH REQUEST

REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION

Please carefully read the information on both sides of this form and the accompanying instructions. INCORRECTLY COMPLETED FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. Use this form to request the confidential information listed below. This form must be signed by a party eligible to receive the information requested. The signature must be notarized.

(Please type or print)

I. CLAIM FILE IDENTIFICATION: Provide the following information to identify the requested claim file.

TWCC or IAB Number	
Employee's Name (Last / First / MI)	
Employee's Social Security Number	– –
Employee's Date of Injury (m m / d d / y y)	– –

II. REQUESTOR INFORMATION: Provide the following information pertaining to the requestor.

Name: Ross Reporting Services		TWCC/Representative Box No. (If Applicable):	
Address: 11706 Playa Court		Prepaid Account No. (If Applicable):	
City, State: Houston, Texas	ZIP: 77034	Telephone No. ( )	☐ Authorized Legal Representative Statement

III. INFORMATION REQUESTED: Please indicate the information and services requested.

Copy Fees: $1.00/first page - $0.30/each additional page. Certification Fee: $1.00

☐ **CLAIM FILE INFORMATION:** Provides paper copies of claim information maintained by the Commission in the original claim file and/or electronic contact data stored on TWCC computer.

- ☐ Certified ☐ Uncertified
- ☐ Expedited Handling Requested ($25.00 Additional Charge)
- ☐ Claim File (Complete)
- ☐ Specific document in file: _____ ☐ Dispute Resolution Contact Data (Electronic)
- ☐ Other (Specify) _____

A FEE STATEMENT WILL BE SENT TO REQUESTOR. COPIES WILL BE AVAILABLE UPON RECEIPT OF PAYMENT.
For additional information contact the TWCC REPROGRAPHICS DEPARTMENT (RECORDS DIVISION) - (512) 385-5161

☐ **MEDICAL RECORDS INFORMATION:** Provides paper copies of claim information maintained in specific TWCC Medical Division records.

Tracking No: _____

- ☐ Expedited Handling Request ($25.00 Additional Charge)
- ☐ Spinal Surgery File (Complete) ☐ Medical Dispute File (Complete)
- ☐ Specific File Document _____
- ☐ Medical Dispute Resolution Contact Data (Electronic)

A FEE STATEMENT WILL BE SENT TO REQUESTOR. COPIES WILL BE AVAILABLE UPON RECEIPT OF PAYMENT.
For additional information contact the TWCC MEDICAL REVIEW DIVISION - DISPUTE RESOLUTION DEPARTMENT (512) 440-3747

☐ **HEARINGS RECORD** Provides information received at TWCC hearings pertaining to disputes between the health care provider, the carrier, the employee, the employer and/or TWCC. (Applies to claims with date of injury after January 1, 1991 only.)

- ☐ Certified ☐ Uncertified **TWCC Docket No:** _____
- ☐ Expedited Handling Requested ($25.00 Additional Charge)
- ☐ Complete Hearings Record
- ☐ Specific document in record: _____ (example: transcript, original petition, etc.)
- ☐ Video Tape (if available) $5.72 ☐ Audio Tape $3.60 each

REQUESTOR WILL BE ADVISED OF CHARGES. COPIES WILL BE AVAILABLE UPON RECEIPT OF PAYMENT.
DEPOSIT REQUIRED FOR TAPE TRANSCRIPTION: $350.00/hour (estimate).
For additional information contact the TWCC Hearings Division - (512) 440-5617.

IMPORTANT: BY EXECUTING THIS FORM, REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. REQUESTOR ALSO ACKNOWLEDGES HIS OR HER LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.

IV. REQUESTOR ELIGILBITY AND NOTARIZATION. (PLEASE CHECK ONE BOX ONLY)

The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from a claim file to the categories of persons listed below. Indicate the category of eligibility which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to TWCC. Eligibility will be verified.

- ☐ The employee or the employee's legal beneficiary
- ☐ The employee's or the legal beneficiary's representative (attach letter of representation)
- ☐ The employer at the time of injury. Requestor must provide injured employee's period of employment: _____ mo./yr. to _____ mo./yr.
- ☐ The Texas Certified Self-Insurer Guaranty Association established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer
- ☐ Health Care Provider who is a party to a Medical Dispute. (Section 413.031 of the Act.)
- ☐ The workers' compensation insurance carrier. Requestor must provide injured employee's date of injury of current claim: _____ mo./dy./yr.
- ☐ The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company
- ☑ A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury. (COPY OF PETITION AND ANSWER THEREIN MUST BE ATTACHED). Requestor must provide injured employee's date of injury: _____ mo./yr.

I have read and understood this form and the accompanying instructions. I am entitled to receive the confidential employee information being requested as indicated above. I understand that it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential information in or derived from an employee's claim file. [Texas Labor Code, Sections 402.084; 402.086 and 402.091]

Name of Requestor: _____
(Please Print)

Position/Title: _____

Firm Name: _____
(if applicable)

Signature: _____ Date: _____

State of _____ *
*
County of _____ *

Before me on the above date personally appeared _____, who after first being sworn, said that the statements contained in this request are true.

Signed _____

Notary Public, State of _____

My Commission Expires _____

FORM TWCC-153
REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION INSTRUCTIONS

1. **FORM TWCC-153 MUST BE COMPLETED IN ITS ENTIRETY.** Please print or type. Send a separate TWCC-153 request form for each TWCC claim number for which you are requesting copies of confidential employee information.

2. A requestor MUST indicate at section IV the legal basis on which he/she is eligible to receive requested confidential employee information. Only individuals in the categories listed are entitled to receive copies of confidential information. See Texas Workers' Compensation Act, Texas Labor Code, Section 402.084(b).

   A. An eligible insurance carrier must have handled a workers' compensation claim for the injured worker.
   B. An out-of-state insurance carrier or employer, or their legal representative, may be eligible to receive confidential claim file information. Documentation of a workers' compensation claim against that employer or the insurance carrier paying that claim must be provided to determine eligibility. (see also number 3 below)
   C. An eligible party to a medical dispute.

3. A party eligible to receive confidential claim file information may authorize a legal representative to request and receive the information on their behalf. Refer to the TWCC Advisory 95-01 for requirements and additional information. Contact Executive Communication at (512) 707-5822 to obtain a copy of this advisory. To establish eligibility to receive confidential claim file information, the legal representative of a party must provide documentation of representation, e.g. letter of representation from client, copy of the contract between the client and the representative or Original Answer.

4. The requestor must swear to the correctness of the entitlement information before a notary public, sign the completed form before the notary, and have the notary complete the sworn acknowledgment. The original signed and notarized form should be mailed or personally delivered to: TEXAS WORKERS' COMPENSATION COMMISSION, 4000 SOUTH IH-35 MS-92B, AUSTIN, TEXAS 78704. Incorrectly attested forms will be returned without action.

5. Copies of this form will be accepted if both sides are an exact reproduction of the original and include an original signature and notarization. To request approval of an alternate TWCC-153, call TWCC EDI Forms and Information Section at (512) 440-3893 for instructions.

6. Indicate if a **certified copy** is requested. The copy of the information requested will have a letter of certification attached which is signed or stamped and sealed by the Custodian of Records, or their delegate, attesting to the authenticity of the attached document(s). See Section III. Certifications are $1.00 additional fee each.

7. The requestor agrees to pay the full amount due TWCC according to the listed fees.

   A. THE FEES MUST BE PAID PRIOR TO THE SHIPMENT OF THE REQUESTED INFORMATION. Fee statements MUST be paid within 30 days of receipt of the statement. Past due amounts will be forwarded to the Texas Attorney General's Office for collection which will require additional costs.
   B. Hearings Division will contact the requestor with billing information for records.
   C. FEES ARE SUBJECT TO CHANGE. Fees for mailed copies will include an additional fee for postage.

8. **Cancellation** of a request for copies of claimant information may be made by calling the responsible division at the telephone number indicated and obtaining a cancellation verification number. Cancellation will NOT relieve requestor of responsibility for payment of amounts owed for services provided PRIOR to notice of cancellation. Cancellation is NOT AVAILABLE after a fee statement has been prepared.

9. **For additional assistance** in completing a request, or to make an inquiry regarding the status of a request, contact the TWCC division responsible for handling the request at the telephone number indicated.

10. To obtain an injured employee's claim history, complete and file Form TWCC-155 Request for Record Check. To obtain a pre-employment check on persons who have been given a tentative offer of employment, complete and file Form TWCC-156 Prospective Employment Authorization and Certification.

11. Governmental agencies/Political Subdivisions, or regulatory bodies requesting copies of confidential claimant information in a capacity other than as an employer, should not complete this form. Please send written request to TWCC Office of General Counsel, M.S. 4D, 4000 South I-H 35, Austin, TX 78704, for determination of eligibility to receive confidential information.

IMPORTANT: BY EXECUTION OF FORM TWCC-153, THE REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A CLASS A MISDEMEANOR FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL CLAIM FILE INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PERSONS (TEXAS LABOR CODE § § 402.084, 402.091). THE REQUESTOR ALSO ACKNOWLEDGES HIS OR HER LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.