STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien (MM/DD/YYYY)*

CASE No.

(Choose only one)

○ a specific injury on

(DATE OF INJURY: MM/DD/YYYY)

○ a cumulative trauma injury beginning on

(START DATE: MM/DD/YYYY)

Thru

(END DATE: MM/DD/YYYY)

SSN (Numbers Only)

Date Of Birth (MM/DD/YYYY)

Injured Worker

First Name	
MI	
Last Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

Attorney/Representative for Injured Worker

Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

Lien Claimant (Completion of this section is required):

Organization*	
First Name*	
Last Name*	
Address/PO Box*	
City*	
State*	
Zip Code* (Numbers Only)	
Phone (Numbers Only)	

Lien Claimant's Attorney / Representative, if any

◯ Law Firm/Attorney ◯ Non Attorney Representative ◯ Lien Claimant Not Represented

Lien Claimant Law Firm/Representative	
First Name	
Last Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	
Phone (Numbers Only)	

Employer

Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

Insurance Carrier or Claims Administrator

Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

Employer or Claims Administrator Attorney/Representative (if known)

Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

Total Lien Amount*

This request and claim for lien is for (mark appropriate box):

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).) (Provider Information section and Declaration pursuant to Labor Code § 4903.05(c) must be completed.)
- ☐ Claims of costs. (Labor Code § 4903.05) Specify nature and statutory basis in the box below.
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ Other Lien(s): Specify nature and statutory basis. Field size limited to 585 characters

If a filing fee is not required, indicate the reason below (choose one):

This is not a lien filed under Labor Code section 4903(b) and is not a claim of costs filed as a lien. ○

This lien is exempt from the filing fee under Labor Code section 4903.05(d)(7). ○

NOTE: ORIGINAL BILL AND ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

Provider Information (Completion of this section is required if filing a lien under Labor Code section 4903(b).)

Provider Type			
Other Provider Type			
Rendering Provider's Name			
Rendering Provider's NPI		Rendering Provider's License/Cert No	
Billing Provider's Name			
Billing Provider's NPI		Initial Date of Service	

Provider Type			
Other Provider Type			
Rendering Provider's Name			
Rendering Provider's NPI		Rendering Provider's License/Cert No	
Billing Provider's Name			
Billing Provider's NPI		Initial Date of Service	

Provider Type			
Other Provider Type			
Rendering Provider's Name			
Rendering Provider's NPI		Rendering Provider's License/Cert No	
Billing Provider's Name			
Billing Provider's NPI		Initial Date of Service	

Declaration pursuant to Labor Code section 4903.05(c). (Completion of this section is required if filing a lien under Labor Code section 4903(b).)

I declare under penalty of perjury under the laws of the State of California that the Lien Claimant is a provider or proper assignee of the provider and the following is true and correct:

• The dispute that is the subject of this lien is not subject to independent medical review and independent bill review; and

The Provider:	(A) is the employee's treating physician providing care through a medical provider network.

(Signature of Lien Claimant) (MM/DD/YYYY)

◯ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

(Signature of Attorney/Representative for Lien Claimant)

(Signature of Lien Claimant) (MM/DD/YYYY)