South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737.5675 www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

The date of injury reported on Form 12A is: _____ (m/d/yyyy)

Check appropriate section(s). The Employer's Representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on _____(m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of _____ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on _____(m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**
- ☐ a. At any time pursuant to § 42-9-260(E).
- ☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____

III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

_____

Claimant reached maximum medical improvement on _____(m/d/yyyy) (copy of medical report must be attached).

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.**

- ☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.
- ☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI. ☐ **Mediation**
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Failure to respond pursuant to Reg. 67-208 B in writing or by submission of a Form 22 may result in ordered mediation pursuant to Reg. 67-1801 B. Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to_____ address_____ on the _____day of _____20___, by ☐ first class postage ☐ certified mail ☐ personal service ☐ electronic service. A $25.00 filing fee and updated Form 18 is required.

_____ _____ _____ _____
Preparer's Signature Title Email Date

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov**
Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.