

Self-Insurance
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Injured Worker Name		Claim Number
Injured Worker Address		
City	State	Zip Code
Date of Injury or Manifestation	Date Form Completed	
Employer Name	UBI	Account ID
Prepared By	Preparer Phone Number (include extension if needed)	

Overpayment Request

The worker must be notified of overpayments within one (1) year of the occurrence. This does not apply to provisional payments.

Type of benefits that were overpaid: <input type="checkbox"/> Time-Loss <input type="checkbox"/> LEP <input type="checkbox"/> PPD	Were the benefits provisional? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a Social Security Offset overpayment request? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Overpayment is due to a wage calculation error (must attach the following) Removed punctuation <ul style="list-style-type: none"> • Copy of the SIF-5A used to calculate the wages • Payment ledgers* and/or LEP calculation worksheets with matching payroll statements • Copy of the Assessment of Overpayment notice sent to the worker 		
<input type="checkbox"/> Overpayment is due to the worker receiving benefits for a period of time they were not entitled (must attach the following) <ul style="list-style-type: none"> • Supporting documentation of a release for work/return to work • Payment ledgers* • Copy of the Assessment of Overpayment notice sent to the worker 		
<input type="checkbox"/> Overpayment is due to a PPD award paid in error or the result of claim closure being reversed		
<p><i>*Payment ledgers must include the payment period(s), amount paid, and the date the payment was sent to the worker.</i></p>		

If needed, provide additional information regarding your request for the overpayment order below.

Attending Provider Information or Update

Please provide the current attending provider information.

Attending Provider Name	Attending Provider's Phone Number	
Attending Provider's Address		
City	State	Zip Code

Translation **for** Communicating the Decision

It is necessary the Employer and the Department ensure a means of communication to all parties per [WAC 296-15-350](#).

Does the worker have a preferred language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", what is the preferred language?
---	---