REQUEST FOR CLAIMS INFORMATION & RECORDS

OKLAHOMA WORKERS' COMPENSATION COMMISSION

1915 N. STILES AVENUE
OKLAHOMA CITY, OK 73105
(405) 522-3222

*** REQUESTS CAN ALSO BE COMPLETED ONLINE AT WWW.CASEOK.WCC.OK.GOV VIA PUBLIC SEARCH TILE**

Part 1: Contact Information and Attestation (Copies of records will be returned to email address listed below.)

REQUESTING PARTY	Name:_____ Address:_____ Telephone: _____ City/State/Zip: _____ Email: _____

I declare under the PENALTY OF PERJURY that the information sought is not requested for a purpose in violation of state or federal law. I understand I am required by law to disclose the person for whom this search request is being made, if different than me. I agree to pay a search fee of $1.00 per search request and any applicable copy charges.

YOUR PRINTED NAME: _____

_____ Signature _____ Date

Part 2: Type of Search (select 1 type only)

◉ By Claimant's Name (first and last):_____

Date of Injury:_____ Commission File No.:_____

○ By Last 5 Digits of SSN: (*Requires worker's written authorization below.*)

Worker's first and last name: _____ Last 5 digits of SSN: XXX-X_____-_____

I authorize the use of my name and last 5 digits of my Social Security Number to Search for prior claims records.

_____ Signature of SSN Holder _____ Date

Part 3: Fees and Exemptions (Requestor may be exempt from $1.00 search fee if any of the following exemptions from 85A O.S. § 120(B)(2) apply. If applicable, please select one exemption.)

☐ 1. The requester is a public officer or a public employee conducting a search in the performance of their duties on behalf of a governmental entity or as may be allowed by law.

☐ 2. The requester is an insurer, self-insured employer, third-party claims administrator, or a legal representative thereof, and the request is necessary to process or defend a workers' compensation claim.

☐ 3. The requester is a worker or the worker's representative.

☐ 4. The disclosure is made for educational or research purposes and in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim.

☐ 5. The requester is a health care or rehabilitation provider or the provider's legal representative, and the information is necessary to process payment of health care or rehabilitation services rendered to a worker.

☐ 6.The requester is an employer or personnel service company, and the worker provides written authorization permitting the search and designating the employer or personnel service company as the worker's representative for that purpose. (***If selected, please provide authorization below.)***

I hereby designate _____ (***name of employer or personnel service company),*** as my representative solely for the purpose of conducting a lawful search of my claims records and provide my authorization to permit such a search.

_____ Employee's Signature _____ Employee's Printed Name _____ Date

TO REQUEST COPIES OF SPECIFIC CLAIM FILE RECORDS, COMPLETE PART 4 BELOW

Return completed request to Records@wcc.ok.gov

Part 4: Type of Records Requested (check all that apply)

(*Required*)
Commission Case No.

_____

☐ **CC-FORM 3** Employee's First Notice of Claim for Compensation
☐ **SETTLEMENT AGREEMENT (JOINT PETITION)** ☐ **WITH ATTACHMENTS**
☐ **FINAL DISPOSITION/ORDER**
☐ **ENTIRE FILE** (File may contain duplicate documents. Billing is for all copies, including any duplicates.)
☐ **OTHER** (please specify):

FOR INTERNAL USE ONLY:

Invoice No. _____ Invoice Date:_____

_____ COPIES at $1.00 per page (85A O.S. § 119) = _____

TOTAL DUE

$ _____

Last updated March 14, 2024