



PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Workers' compensation complaint form

Este formulario está disponible en español en el sitio web de la División en

www.tdi.texas.gov/forms/dwc/dwc154compl.pdf.

Para obtener asistencia en español, llame a la División al 800-252-7031.

Part 1: Complainant information (person filing complaint)

1. Name* (first, middle, last)	2. Date of complaint (mm/dd/yyyy)	3. Email address
4. Address (street or PO box, city, state, ZIP code)		5. Phone number ()

*Required under Texas Labor Code [Section 402.023\(d\)\(2\)](#)

Part 2: Injured employee information

6. Name (first, middle, last)	7. DWC claim # (if known)
8. Employer (at time of injury)	9. Date of injury (mm/dd/yyyy)

Part 3: Alleged violator information (person or company complaint is against)

10. Name
11. Alleged violator role on claim (mark one) <input type="checkbox"/> Insurance carrier <input type="checkbox"/> Health care provider <input type="checkbox"/> Designated doctor <input type="checkbox"/> Other <input type="checkbox"/> Injured employee (IE) <input type="checkbox"/> IE representative <input type="checkbox"/> Employer <input type="checkbox"/> Unknown

Part 4: Complaint

A **complaint** is a written allegation that a system participant has violated [Texas Labor Code, Title 5, Subtitle A](#) or Texas Department of Insurance, Division of Workers' Compensation's (DWC) [rules](#). If your issue is a **complaint**, please describe the facts of the alleged violation of workers' compensation laws or rules in the space below. Attach additional pages if necessary. Include the following information:

- The dates or time period during which the violation occurred;
- The nature of the violation, including specific sections of Texas Labor Code, Title 5, Subtitle A or DWC rules alleged to have been violated, if known;
- The name and contact information of the subject of or parties to the complaint, if known; and
- The name and contact information of witnesses, if known.

Example: By failing to send my impairment income benefit check for the week of December 13, ABC Insurance Company violated Texas Labor Code [Section 408.081](#), which requires weekly payment of income benefits. The insurance adjuster is Mr. Jones, and his phone number is 512-555-1234.

12. Description of complaint

FAQ

What types of documentation should I submit to support my complaint?

Please submit any supporting documentation with your complaint. Supporting documentation may include:

- Medical bills;
- Explanations of benefits;
- Copies of invoices or checks;
- Evidence of communications (written correspondence or documentation of conversations) between you and the insurance carrier; attorney; or health care provider, including names, dates, and phone numbers;
- Proof of timely submission or filing (for example, certified receipts or fax receipts);
- Off-work slips;
- Copies of relevant DWC forms;
- Photographs, reports, and recordings (video, audio, surveillance) if fraud is alleged; and
- Any other documentation to support your complaint.

Where can I find additional information about complaints?

- Texas Labor Code [Section 402.023](#), Complaint Information, and [Section 402.0235](#), Priorities for Complaint Investigations;
- 28 Texas Administrative Code [Section 180.2](#), Filing a Complaint; and
- The "File a Complaint" section on DWC's website at <https://www.tdi.texas.gov/wc/ci/wccomplaint.html>.

Is the information I submit confidential?

The information in DWC's investigation files is confidential under Texas Labor Code [Section 402.092](#) and generally may not be disclosed except:

- In a criminal proceeding;
- In a hearing conducted by DWC;
- On a judicial determination of good cause;
- To a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of the laws of Texas, another state, or the United States; or
- To an insurance carrier if the investigation file relates directly to a felony regarding workers' compensation or to a claim in which restitution is required to be paid to the insurance carrier.

In addition, DWC investigation files are not open records for purposes of Government Code, [Chapter 552](#), Public Information Act. Information in or derived from a claim file is governed by Texas Labor Code Sections [402.083-402.085](#).

How do I submit my complaint and supporting documentation to DWC?

Email: DWCCOMPLAINTS@tdi.texas.gov
Fax: 512-490-1030
In person: [DWC field office](#)
Mail: Texas Department of Insurance, Division of Workers' Compensation
 Compliance and Investigations, Mail Code CI
 PO Box 12050
 Austin, TX 78711

For questions on or help with submitting a workers' compensation complaint, call 1-800-252-7031.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you;
- Receive and review the information (Government Code [Sections 552.021](#) and [552.023](#)); and
- Have DWC correct information that is incorrect (Government Code [Section 559.004](#)).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure at www.tdi.texas.gov.