

Information & Assistance Unit guide 10

How to file a lien

Filing a notice and request for allowance of lien is how you make a claim for payment of money you're owed in a workers' compensation case.

Attached is a lien form. Complete the form. Be sure to sign and date it. This form can also be completed at <http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCFORM6.pdf>.

Attach a full statement or itemized bill supporting the lien.

A Workers' Compensation Appeals Board (WCAB) case number must be entered in the top right hand corner of the lien. If there is no WCAB case number, contact the local Information & Assistance (I&A) office.

Send the original to your local WCAB district office and copies to all parties. It is important that you check the box indicating all parties have been served. Submit the following documents with your form filing in the order shown:

- ✓ [Document Cover Sheet](#)
- ✓ [Document Separator Sheet](#) (*for Notice and Request for Allowance Of Lien*)
- ✓ [Notice and Request for Allowance Of Lien](#)
- ✓ [Document Separator Sheet](#) (*for Proof of Service By Mail*)
- ✓ [Proof of Service By Mail](#)

There are also time limitations for medical providers and medical-legal lien claimants to file liens. Such liens must be filed:

1. Within six months of a final decision, findings, award or order, including an order approving a compromise and release
2. Within five years of the date of injury
3. Or within one year of the date the services were provided, whichever is later. The employee's consent to allowance of lien and signature are not required.

Keep a copy for your records.

EDEX subscribers may also use DWC's EDEX system to electronically file liens with the WCAB. For more information, contact the EDEX administrator at DWC, P. O. Box 420603, San Francisco, CA 94142 or at eliens@dir.ca.gov.

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All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an [Information and Assistance \(I&A\) office](#), or attend a [workshop for injured workers](#). The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

If you do not have the name and address of your insurance company to complete a form, please link to <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806

1065 N. PacifiCenter Dr., Suite 202
Information & Assistance Unit (714) 414-7401

BAKERSFIELD, 93301-1929

1800 30th Street, Suite 100
Information & Assistance Unit (661) 395-2514

EUREKA, 95501-0481

100 "H" Street, Suite 202
Information & Assistance Unit (707) 441-5723

FRESNO, 93721-2280

2550 Mariposa Street, Suite 4078
Information & Assistance Unit (559) 445-5355

GOLETA, 93117-3018

6755 Hollister Avenue, Suite 100
Information & Assistance Unit (805) 968-4158

GROVER BEACH, 93433-2261

1562 W. Grand Avenue
Information & Assistance Unit (805) 481-3380

LONG BEACH, 90802-4339

300 Oceangate Street, Suite 200
Information & Assistance Unit (562) 590-5240

LOS ANGELES, 90013-1105

320 West 4th Street, 9th Floor
Information & Assistance Unit (213) 576-7389

MARINA DEL REY, CA 90292

4720 Lincoln Blvd. 2nd and 3rd floors
Information & Assistance Unit (310) 482-3858

OAKLAND, 94612-1402

1515 Clay Street, 6th Floor
Information & Assistance Unit (510) 622-2861

OXNARD, 93030

2220 East Gonzales Road, Suite 100
Information & Assistance Unit (805) 485-3528

POMONA, 91766-1601

732 Corporate Center Drive
Information & Assistance Unit (909) 623-8568

REDDING, 96001-2796

2115 Civic Center Drive, Suite 15
Information & Assistance Unit (530) 225-2047

RIVERSIDE, 92501-3337

3737 Main Street, Suite 300
Information & Assistance Unit (951) 782-4347

SACRAMENTO, 95034

160 Promenade Circle Suite 300
Information & Assistance Unit (916) 928-3158

SALINAS, 93906-2204

1880 North Main Street, Suites 100 & 200
Information & Assistance (831) 443-3058

SAN BERNARDINO, 92401-1411

464 West Fourth Street, Suite 239
Information & Assistance Unit (909) 383-4522

SAN DIEGO, 92108

7575 Metropolitan Drive, Suite 202
Information & Assistance Unit (619) 767-2082

SAN FRANCISCO, 94102-7002

455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit (415) 703-5020

SAN JOSE, 95113-1482

100 Paseo de San Antonio, Suite 241
Information & Assistance Unit (408) 277-1292

SANTA ANA, 92701-4070

605 W Santa Ana Blvd, Bldg 28, Suite 451
Information & Assistance Unit (714) 558-4597

SANTA ROSA, 95404-4760

50 "D" Streets, Suite 420
Information & Assistance Unit (707) 576-2452

STOCKTON, 94202

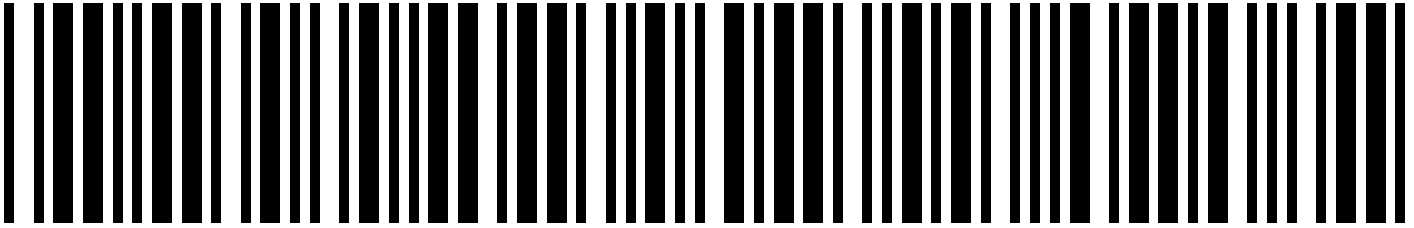
31 East Channel Street, Suite 344
Information & Assistance Unit (209) 948-7980

VAN NUYS, 91401-3373

6150 Van Nuys Blvd., Suite 105
Information & Assistance Unit (818) 901-5374

DOCUMENT SEPARATOR SHEET

SAMPLE



Product Delivery Unit ADJ

Document Type LIENS AND BILLS

Document Title NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

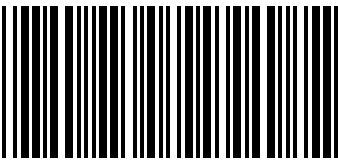
Document Date DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author YOUR NAME

Office Use Only

Received Date _____
MM/DD/YYYY





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

SAMPLE

Date Of Original Lien: _____
MM/DD/YYYY

Original Lien

Amended Lien

EAMS CASE NUMBER

Case No. _____

(Choose only one)

a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

INJURED WORKER'S SSN

SSN (Numbers Only) _____

(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

INJURED WORKER'S FIRST NAME

First Name _____ MI _____

INJURED WORKER'S LAST NAME

Last Name _____

INJURED WORKER'S ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

INJURED WORKER'S CITY

City _____ State _____ Zip Code _____

Attorney/Representative for Injured Worker:

NAME OF INJURED WORKER'S ATTORNEY

Name _____

ATTORNEY ADDRESS

Address/PO Box (Please leave blank spaces between numbers , names or words)

ATTORNEY CITY

City _____ State _____ Zip Code _____

Lien Claimant (Completion of this section is required):

NAME OF ORGANIZATION FILING LIEN

Name of Organization filing lien (for individual lien claimants, leave blank)

FIRST NAME OF CONTACT

First Name of Individual filing lien(organizational lien claimants, leave blank)

LAST NAME OF CONTACT

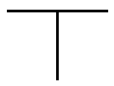
Last Name of Individual filing lien(organizational lien claimants, leave blank)

ORGANIZATION ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

ORGANIZATION CITY

City _____ State _____ Zip Code _____



Lien Claimant's Attorney/Representative, if any

Law Firm/Attorney Non-Attorney Representative Lien Claimant not represented

LIEN CLAIMANT LAW FIRM OR REPRESENTATIVE - USE UNIFORM ASSIGNED NAME

Lien Claimant Law Firm/Representative

REPRESENTATIVE FIRST NAME

First Name

REPRESENTATIVE LAST NAME

Last Name

LAW FIRM OR REPRESENTATIVE ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

LAW FIRM OR REPRESENTATIVE CITY

City

State

Zip Code

LAW FIRM OR REPRESENTATIVE PHONE

Phone

Employer

NAME OF COMPANY INJURED WORKER WAS WORKING FOR

Name

COMPANY ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

COMPANY CITY

City

State

Zip Code

Insurance Carrier or Claims Administrator

CLAIMS ADMINISTRATOR - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

ADMINISTRATOR CITY

City

State

Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

ADMINISTRATOR LAW FIRM - USE UNIFORM ASSIGNED NAME

Name

ADMINISTRATOR LAW FIRM ADDRESS

Address/PO Box (Please leave blank spaces between numbers, names or words)

ADMINISTRATOR LAW FIRM CITY

City

State

Zip Code

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

SELECT ONE OR MORE REASONS

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).)
- Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- 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 reasonable fee for interpreter's services performed on _____ 20 ____ . (Labor Code § 4600 (f).)
- The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- Other Lien(s): Specify nature and statutory basis.

[Empty box for itemized statement justifying the lien]

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

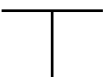
- A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

TODAY'S DATE

(Signature of Attorney/Representative for Lien Claimant)

(Signature of Lien Claimant)

Date (MM/DD/YYYY)



Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of YOUR COUNTY California. I am over the age of eighteen years, my (business/residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT on the INSURANCE COMPANY in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at CITY WHERE YOU MAILED THIS addressed as follows

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) TODAY'S DATE, at CITY California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of _____ California. I am over the age of eighteen years, my (business/residence) address is:

On _____, I served the attached _____ on the _____ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at

_____ addressed as follows _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) _____, at _____ California.

Type or print name _____

Signature _____