TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(800) 252-7031 | TDI.texas.gov | @TexasTDI

SUBMIT A SEPARATE DWC FORM-153 FOR EACH INJURED EMPLOYEE

REQUEST FOR RECORD CHECK OR COPIES OF CONFIDENTIAL CLAIM INFORMATION

This form must be signed by a party eligible to receive the information requested.

Este formulario está disponible en español en el sitio web de la División en www.tdi.texas.gov/forms/dwc/dwc153srec.pdf.
Para obtener asistencia en español, llame a la División al 800-252-7031.

I. INJURED EMPLOYEE INFORMATION

1. DWC Claim Number (Required if box 15 is not checked.)	**2. Employee Social Security Number**
3. Employee Name (First, Middle, Last)	
4. Date of Birth (mm-dd-yyyy)	**5. Date of Injury** (mm-dd-yyyy) (Required if box 15 is not checked.)
6. Employee Address (Street or P.O. Box, City, State, ZIP Code)	

II. REQUESTER INFORMATION

7. Name (First, Middle, Last)	**8. DWC Representative Box Number** (if applicable)
9. Position or Title (if applicable)	**10. Firm Name** (if applicable)
11. Address (Street or P.O. Box, City, State, ZIP Code)	**12. Email Address**
13. Phone Number	**14. Fax Number**

III. INFORMATION REQUESTED Please check a box to indicate the information you are requesting.

RECORD CHECK

☐ **15. Record Check:** Requesters will be provided the DWC claim number, date and nature of the injury, employer at the time of injury, whether the injured employee has received income benefits, and disposition of the claim for dates of injury before January 1, 1991.

OR

COPIES OF CONFIDENTIAL CLAIM INFORMATION

☐ **16. Claim File** ☐ **DRIS Notes Only**	☐ **17. Medical Fee Dispute Resolution File** (date of injury after January 1, 1991) **Tracking Number*:** ☐ **Complete File** ☐ **Specific Document:**
☐ **18. Indemnity Dispute Resolution File** (date of injury after January 1, 1991) **Dispute Sequence No:** ☐ **Complete File** ☐ **Specific Document:** ☐ **Audio Recording of Hearing** ☐ **Video or Audio Evidence** (if any)	
19. Certified copy? ☐ **Yes** ☐ **No**	**20. Format to receive documents:** ☐ **Electronic or** ☐ **Paper**

*Required for a copy of a medical fee dispute resolution file.

IV. REQUESTER ELIGIBILITY

21. Requester Categories

The Texas Labor Code limits the release of confidential claim information to the requesters below. **Requester represents that he or she is entitled to the information requested and has authority to request the information.**

Check only one box:

- ☐ The employee.
- ☐ The employee's legal beneficiary. *(**Attach documentation**)*
- ☐ The employee's or the legal beneficiary's representative. *(**Attach documentation**)*
- ☐ The employer at the time of injury. Requester must provide injured employee's period of employment. *(**Attach documentation**)*
- ☐ The workers' compensation insurance carrier.
- ☐ The insurance carrier's legal counsel or representative. *(**Attach documentation**)*
- ☐ The Texas Certified Self-Insurer Guaranty Association established under Texas Labor Code, Chapter 407, Subchapter G, if that association has assumed the obligations of an impaired employer.
- ☐ The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company.
- ☐ A third-party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury. Requester must provide injured employee's date of injury. (***Attach copy of Petition and Answer***)
- ☐ Health care provider who is a party to a medical dispute under Texas Labor Code Section 413.031(c).

I certify that I am entitled to receive the confidential claim information requested. **I understand** that it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential information in or derived from an employee's claim file. Texas Labor Code Sections 402.064, 402.081, 402.083, 402.084, 402.086, and 402.091.

22. Signature of Requester	
23. Printed Name of Requester	**24. Date of Signature** (mm-dd-yyyy)

Frequently Asked Questions

Request for Record Check or Copies of Confidential Claim Information (DWC Form-153)

Who may request confidential claim file information?

Only the requester categories listed in Section IV are entitled to receive confidential claim information. See Texas Labor Code Section 402.084. Governmental agencies or political subdivisions requesting copies of confidential claim information in a capacity other than as an employer should not complete this form. Please contact DWC Legal Services at 512-804-4275 for more information on eligibility to receive confidential information.

- An eligible insurance carrier must have handled a workers' compensation claim for the injured employee. Documentation of a workers' compensation claim must be provided to determine eligibility.
- A lay person, legal representative, or other party may be eligible to receive confidential claim file information if the injured employee authorizes them to request and receive the information on their behalf. To establish eligibility, the party must provide documentation of representation (for example, a letter of representation from the client, copy of the contract between the client and the representative, or the defendant's original answer).

What are my options for receiving confidential claim file information?

- **Electronic** – Documents and other requested media will be provided through the GovQA website and notice will be sent to the requester's email. Insurance carriers will receive their copies through their Austin representative's secure file transfer protocol box.
- **Paper** – Documents will be printed and mailed to the requester. A fee may be charged depending on the number of printed documents. See below for more information about fees.
- **Certified** – The copy of the information requested will have a letter of certification attached, which is signed and stamped by the Custodian of Records and attests to the authenticity of the attached documents.

Are any fields on the DWC Form-153 optional?

All applicable fields must be completed each time a DWC Form-153 is submitted.

- **Section I** – all fields are required for claim file and indemnity dispute resolution file requests. Employee name, Social Security number, and date of birth are required for record check requests. All fields except date of birth are required for the medical fee dispute resolution file.
- **Section II** – all fields are required, if applicable. An email address is required to notify that electronic documents are ready for pick up. The email address is confidential under Texas Government Code Section 552.137 and will not be released without your consent.
- **Section III** – enter information in the specified fields for records you are requesting. The medical dispute resolution file tracking number is required for a copy of a medical fee dispute resolution file.
- **Section IV** – you must indicate the legal basis on which you are eligible to receive requested confidential claim information and provide any additional information in the documentation you attach to the request.

Incorrect or incomplete forms will be returned.

Can I request a record check and copies of confidential claim information for the same injured employee on the same request?

No. Injured employees may have multiple claims, so you must submit a separate DWC Form-153 to request copies of confidential claim information for a specific claim.

How do I submit the DWC Form-153?

The original signed form can be attached to an open records request at tdi.texas.gov/open-records.html, faxed to DWC Legal Services at 512-804-4276, mailed, or personally delivered. Do not fax this request to any other DWC fax number. You must submit a separate DWC Form-153 for each injured employee.

Will I be charged a fee for copies of confidential claim file information?

DWC will give you electronic copies at no cost. We may charge a fee if you ask for paper copies, depending on the number of pages.

How can I get more information?

If you are requesting copies of a claim file or for help completing this form, call DWC Legal Services at 512-804-4703.

***IMPORTANT:* By submitting DWC Form-153, the requester represents that he or she is entitled to the information requested and that he or she has full authority to act as a requester. It is a Class A misdemeanor for an unauthorized person to receive confidential claim file information or to disclose such information to an unauthorized person. Texas Labor Code Sections 402.064, 402.081, 402.083, 402.084, 402.086, and 402.091.**