TDI Division of Workers' Compensation

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

Governmental entity coverage information

Part 1. Governmental entity information

1. Name	**2. Coverage effective dates** (mm/dd/yyyy) From: To:
3. Physical address (street, city, state, ZIP code)	**4. Federal employer identification number** (FEIN)
5. Contact name	**6. Contact phone number**
7. Contact email	**8. Date this form is completed** (mm/dd/yyyy)

9. How is the governmental entity providing workers' compensation benefits for the coverage period?

Choose one option and follow the instructions for that option.

☐ Self-insurance. (If you check this box, complete **Part 2. Claim administration contact information.** Do not leave any field blank.)

☐ Interlocal agreement with other governmental entities, also known as a pool. Complete the following:

a. Pool or group name:

b. FEIN:

c. Contact name:

d. Contact phone number:

e. Contact email:

Part 2. Claim administration contact information

Claim adjustment

16. Business name	**17. Effective date** (mm/dd/yyyy)
18. Business address (street or PO box, city, state, ZIP code)	
19. Email	
20. Phone number	**21. Fax number**
22. Comments	

Coverage verification

23. Business name	24. Effective date (mm/dd/yyyy)
25. Business address (street or PO box, city, state, ZIP code)	
26. Email	
27. Phone number	28. Fax number
29. Comments	

Medical billing

30. Business name	31. Effective date (mm/dd/yyyy)
32. Business address (street or PO box, city, state, ZIP code)	
33. Email	
34. Phone number	35. Fax number
36. Comments	

Pharmacy billing

37. Business name	38. Effective date (mm/dd/yyyy)
39. Business address (street or PO box, city, state, ZIP code)	
40. Email	
41. Phone number	42. Fax number
43. Comments	

Preauthorization

44. Business name	45. Effective date (mm/dd/yyyy)
46. Business address (street or PO box, city, state, ZIP code)	
47. Email	
48. Phone number	49. Fax number
50. Comments	

Workers' compensation health care network or medical benefits plan

51. Business name	**52. Effective date** (mm/dd/yyyy)
53. Business address (street or PO box, city, state, ZIP code)	
54. Email	
55. Phone number	**56. Fax number**
57. Comments	

FAQ

Governmental entity coverage information

When do I file this form?
You must file DWC Form-020SI, *Governmental entity coverage information*:

- **Within 10 days** after the effective date of self-insurance coverage or claim administration agreement and each year after that, no later than 10 days after the anniversary date of coverage or agreement;
- **Within 30 days** after the date the political subdivision begins to provide medical benefits in accordance with Texas Labor Code Section 504.053(b)(2);
- **Within 30 days** of any change in the manner the political subdivision provides medical benefits;
- **On** joining, leaving, or changing pools or groups; and
- **On** buying a workers' compensation insurance policy.

Note: A governmental entity may be subject to administrative penalties if it fails to file the DWC Form-020SI.

I provide workers' compensation coverage through a private workers' compensation insurance carrier. Am I required to file this form?
No, you are not required to file the DWC Form-020SI.

Are any fields on the form optional?
If self-insurance is selected in question 9, complete Part 2. If interlocal agreement is selected in question 9, complete the pool details in 9 a. through 9 e.

Where do I send this form?

- Email: coverage.verification@tdi.texas.gov
- Fax: 512-804-4146
- Create a profile in TXCOMP and upload documents.

Questions?
Email questions to coverage.verification@tdi.texas.gov.

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 go to the Corrections Procedure section at www.tdi.texas.gov.