pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

REQUEST FOR HEARING TO CONTEST FEE REVIEW DETERMINATION

PATIENT/EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - __ - ____ _____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

_____

PROVIDER

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
Specialty _____
Contact _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
Contact _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

PATIENT/EMPLOYEE

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

EMPLOYER

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____ FEIN _____

THIS REQUEST IS BEING FILED BY: ☐ **HEALTH CARE PROVIDER** ☐ **INSURER/EMPLOYER**

FEE REVIEW APPLICATION NUMBER(S) AND DATE OF FEE REVIEW DETERMINATIONS(S):

Application number: _____ Determination date: _____
Application number: _____ Determination date: _____
Application number: _____ Determination date: _____

TO THE FEE REVIEW HEARING OFFICE:

I hereby request a de novo hearing by a fee review hearing officer under 34 Pa. Code §127.257 in the above-referenced Fee Review Application(s).

a. The following bills are disputed:

BILLING FORM	DATE OF BILL	SERVICE DATE	PROC/SVC CODE	AMOUNT BILLED

b. The following ***factual*** issues relative to the medical payment matter are in dispute. Concisely state all factual issues. **Do Not attach supplemental pages**.

c. The following ***legal*** issues are in dispute. Concisely cite the specific statutory and regulatory authority asserted to be relevant and/or applicable in this matter. **Do Not attach supplemental pages**.

Requesting Party or Representative's signature

Requesting Party or Representative's name (typed/printed)

Telephone

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

COUNSEL FOR RESPONDENT (if known):

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. A copy must be sent to the prevailing party in the fee review determination that you are appealing. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known.

All requests for a hearing will be returned if not signed and dated. Do not attach documents to this request. The Workers' Compensation Office of Adjudication will destroy all attachments and will NOT process them or return them to you.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program