pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

APPLICATION FOR FEE REVIEW PURSUANT TO SECTION 306 (F.1)

PATIENT/EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER ___ - __ - ____ __________

DATE OF INJURY __ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER _______

PATIENT/EMPLOYEE

First name ______
Last name ______
Date of birth ______
Address ______
Address ______
City/Town ______ State ______ ZIP ______
County ______
Telephone ______

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name ______
Address ______
Address ______
City/Town ______ State ______ ZIP ______
County ______
Telephone ______
Contact ______
NAIC code ______ or Insurer code ______
(*Required: see BWC Website for NAIC or Insurer codes)
Insurer/TPA Claim # ______
FEIN ______

EMPLOYER

Name ______
Address ______
Address ______
City/Town ______ State ______ ZIP ______
County ______
Telephone ______ FEIN ______

PROVIDER

Name ______
Address ______
Address ______
City/Town ______ State ______ ZIP ______
Telephone ______
Federal tax ID number ______
MC Provider #NPI # ______
Specialty ______
Contact ______

PROVIDER REPRESENTATIVE or CORRESPONDENCE ADDRESS (if Other than Above)

Name ______
Address ______
Address ______
City/Town ______ State ______ ZIP ______
Telephone ______

NOTICE: Section 306(f.1)(5) of the Workers' Compensation Act requires that the Application for Fee Review must be filed not more than 30 days following notification of a disputed treatment or 90 days following the original billing date of treatment, whichever is later.

INSTRUCTIONS:

If not filing electronically, this form must be used to request medical fee review pursuant to Section 306 (f.1)(5) of the Workers' Compensation Act. Your application will be returned and your request for review may not be considered until all requested documentation is provided per Sections 127.252(b) and 127.253 of the Rules and Regulations.

NOTE: If not filing electronically, send the original to: Bureau of Workers' Compensation, Medical Fee Review Section
651 Boas Street, 8th Floor, Harrisburg, PA 17121-0750

PROOF OF SERVICE

I hereby certify that on ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY), I served copies of the Application for Fee Review and the attached supporting documentation to ______________________________

Insurer/Employer

____

Street address

______________________________ via

City/Town State ZIP

____

First class mail, overnight mail, etc.

____

Provider or representative's signature
(Note: Request will be returned if not signed and dated)

____

Provider or representative's name (Typed/Printed)

____

Telephone

This is an Act 46 (firefighter cancer) claim ☐

Review being requested for: ☐ **Amount of payment** ☐ **Timeliness of payment** ☐ **Both**

Dates of service From	Dates of service To	Date bill originally submitted to carrier:	Paid	Denied	Paid part/ Denied part	No response from insurer
MM - DD - YYYY	MM - DD - YYYY	MM - DD - YYYY	☐	☐	☐	☐
MM - DD - YYYY	MM - DD - YYYY	MM - DD - YYYY	☐	☐	☐	☐
MM - DD - YYYY	MM - DD - YYYY	MM - DD - YYYY	☐	☐	☐	☐
MM - DD - YYYY	MM - DD - YYYY	MM - DD - YYYY	☐	☐	☐	☐

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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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