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
1171 South Cameron Street, Harrisburg, PA 17104-2597

PROOF OF SERVICE

I hereby certify that on ___ - ___ - _____, I served copies of the Application for Fee Review and the attached
MM DD YYYY

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