

REQUEST FOR HEARING TO CONTEST FEE REVIEW DETERMINATION

PATIENT/EMPLOYEE SOCIAL	SECURITY NUMBER OR WC II	O NUMBER	DATE OF IN		WCAIS CLAIM NUMBER	
PROVIDER		INSU	RER or THIRD	PARTY ADMINIS	TRATOR (if self-insured)	
Name		Nam	e			
Address		Addr	ess			
Address		Addr	ess			
City/Town	State ZIP	City/	Town	State _	ZIP	
County		Cour	nty			
Telephone	FEIN	Telep	ohone	FEIN _		
Specialty		Cont	act			
Contact		NAIC	code	or Insu	rer code	
PATIENT/EMPLOYEE		Insu	rer/TPA claim #			
First name		ЕМРІ	.OYER			
Last name		Nam	e			
Date of birth		Addr	ess ———			
Address		Addr	ess			
Address		City/	Town	State _	ZIP	
City/Town	State ZIP	Telep	hone	FEIN _		
_	ING FILED BY: HEA	Determ				
			Determination date:			
Review Application(s).	EARING OFFICE: novo hearing by a fee reviewing bills are disputed: DATE OF BILL	ew hearing officer un SERVICE DATE		§127.257 in the a	AMOUNT BILLED	

	tual issues relative to the medi upplemental pages.	cal payment matter are in dispute. (Concisely state all factual issues.		
c. The following lega relevant and/or a	al issues are in dispute. Concise pplicable in this matter. Do No t	ely cite the specific statutory and rec	gulatory authority asserted to be		
Requesting Party or Representative's signature		Requesting Party or Represe	entative's name (typed/printed)		
		Attorney ID (if representati	ive is counsel)		
		E-mail Address			
		Telephone			
		Address			
		Address			
		City/Town	State ZIP		
		If you are an attorney, or if you wish to be represented by an attorney, said attorney must formally enter their appearance through WCAIS. Until then, all notices will go to the current parties of record.			
1010 N. Seventh St, Suite 202, H	larrisburg, PA, 17102-1400. A copy must	ctronically, the original must be sent to the Wor be sent to the prevailing party in the fee review led by you verifying that you have sent a copy o			
	e returned if not signed and dated. Do not NOT process them or return them to you	attach documents to this request. The Workers	' Compensation Office of Adjudication will		
		the intent to defraud is in violation of Section 11 r 18 Pa. C.S.A. §4117 (relating to insurance fraud	02 of the Pennsylvania Workers' Compensation Act.		

Employer Information Services717.772.3702

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

