## 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 WCAIS CLAIM NUMBER
	MM DD YYYY
PROVIDER	INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)
Name	Name
Address	Address
Address	Address
City/Town StateZIP	City/Town State ZIP
County	County
Telephone FEIN	Telephone FEIN
Specialty	Contact
Contact	NAIC code or Insurer code
PATIENT/EMPLOYEE	Insurer/TPA claim #
First name	EMPLOYER
Last name	Name
Date of birth	Address
Address	Address
Address	City/TownState ZIP
City/Town State ZIP	Telephone FEIN
THIS REQUEST IS BEING FILED BY: HEALTH CARE F	
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 o Review Application(s).	fficer under 34 Pa. Code §127.257 in the above-referenced Fee
a. The following bills are disputed:	

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

<ul> <li>b. The following <i>factual</i> issues relative to the medi Do Not attach supplemental pages.</li> </ul>	cal payment matter are in dispute. Con	cisely state all factual issues.			
c. The following <i>legal</i> issues are in dispute. Concise relevant and/or applicable in this matter. <b>Do No</b>	ely cite the specific statutory and regula t attach supplemental pages.	tory authority asserted to be			
uesting Party or Representative's signature	Requesting Party or Representa	ative's name (typed/printed)			
	Attorney ID (if representative i	Attorney ID (if representative is counsel)			
	E-mail Address				
	Telephone				
	Address				
	Address				
	City/Town	State ZIP			
	If you are an attorney, or if you wish t attorney must formally enter their app notices will go to the current parties of	pearance through WCAIS. Until then, a			

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 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



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