Reset Form

PROVIDER FEE REQUEST FOR ASSISTANCE

State Form 52875 (R / 11-14)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, Indiana 46204
Telephone: (317) 232-3808
Toll free: (800) 824-COMP

* This agency is requesting disclosure of the employee's Social Security Number in accordance with 631 IAC 1-1-32; disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS: 1. *Please print or type.*
2. *Return completed request to the address listed above.*

PROVIDER INFORMATION			EMPLOYER INFORMATION
Name of provider			Name of employer
Address *(number and street)*			Address *(number and street)*
City, state, and ZIP code			City, state, and ZIP code
Telephone number ( )	National Provider Identification number (NPI)		Telephone number ( )
Date(s) of service *(month, day, year)*	Amount owed	☐ Total bill ☐ Balanced bill	County of employment
Date(s) billing / claim submitted to carrier / TPA *(month, day, year)*			**WORKER'S COMPENSATION INSURANCE / THIRD PARTY ADMINISTRATOR (TPA) INFORMATION**
Date initial written communication received after bill submission *(month, day, year)*			Name of company
Name of employee treated / provided services			Name of adjustor
Social Security Number of employee *			Insurance claim number
Have you hired an attorney?			Telephone number ( )
If Yes, name and telephone number of attorney			Contact person(s)

Briefly describe your complaint / dispute *(Attach claim forms submitted.)*

I hereby request the medical claims reviewer of the Worker's Compensation Board to investigate my complaint. I understand that the medical claims reviewer is not a replacement for legal counsel, and that any specific legal questions should be addressed to my attorney.

Signature of authorized representative	Date *(month, day, year)*