Reset Form

APPLICATION FOR ADJUSTMENT OF CLAIM FOR PROVIDER FEE

State Form 18487 (R7 / 1-15)
Approved by State Board of Accounts, 2015

WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204-2753
Telephone: (317) 232-3808

FOR STATE USE ONLY
Application number

INSTRUCTIONS:
1. *The application must file an original and two (2) copies of this application for it to be processed.*
2. *Mail to the Worker's Compensation Board at the above address.*
3. *For detailed instructions, go to www.in.gov/wcb/files/Provider_Memo.pdf.*

PLAINTIFF vs DEFENDANT

Plaintiff		Defendant	
Name of plaintiff *(provider)*		Name of defendant *(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 ( )	Federal identification number
Name of attorney *(must complete)*		Name of insurance carrier	Insurance claim number
Address *(number and street)*		Address *(number and street)*	
City, state, and ZIP code		City, state, and ZIP code	
Telephone number ( )	E-mail address	Name of adjuster	
Attorney number		Telephone number ( )	E-mail address
		Billing review company	
		Name of reviewer	
		Telephone number ( )	E-mail address

VS

Must check one: ☐ Total Billing *(no payment received)*
☐ Balance Billing *(partial payment received)*
☐ Single ☐ Bundled

For Balance Billing *(A $60.00 filing fee must accompany the application.):*
Check number: _____

THE PLAINTIFF RESPECTFULLY REPRESENTS TO THE BOARD AS FOLLOWS:

That the defendants, as employer and employer's compensation insurance carrier, owe and are indebted to the plaintiff on account in the sum of _____ dollars for provider's fee and supplies in the treatment of the injuries of _____
Name of patient
incurred as a result of an injury / illness arising out of and in the course of the employment with the defendant employer, on the _____ day of _____ , 20 _____ , in the county of _____ .

The patient's date of birth is *(month, day, year)*: _____

The patient's address is *(number and street, city, state, and ZIP code)*: _____

Latest date of service *(month, day, year)*: _____

That said services were rendered as follows *(check all that apply)*:
☐ In an emergency
☐ The employer failed to provide such service
☐ The employee was in need of timely services provided
☐ Employer or insurance carrier approved such services

Provider first requested payment for said services on *(month, day, year)*: _____

The applicant certifies that required diligence has been accomplished and that the initial written response from the employer / representative was received on *(month, day, year)*: _____

Additional date(s) demands made *(month, day, year)*: _____

Date(s) of follow-up *(month, day, year)*: _____

Type of second request: ☐ Oral ☐ E-mail ☐ Written Date(s) *(month, day, year):* _____

Wheretofore the plaintiff prays to the Board to find against the defendant on said account the sum of $ _____ .

Signature of plaintiff	Date signed *(month, day, year)*