APPLICATION FOR ADJUSTMENT OF CLAIM FOR PROVIDER FEE

State Form 18487 (R6 / 5-11)
Approved by State Board of Accounts, 2011

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

INSTRUCTIONS:
1. *The applicant 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.*

FOR STATE USE ONLY
Application number

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 ( )	Federal identification number	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*)