

Send original to
Workers' Compensation Court and 1 copy to:
Insurance Carrier, Self-Insured Employer/Own
Risk Group or Uninsured Employer

In re claim of:

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| Full Name of Injured Employee (Claimant) |
| Employee's Social Security Number |
| Name of Employer (Respondent) |
| Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured |

REQUEST FOR ADMINISTRATIVE REVIEW OF DISPUTED MEDICAL CHARGES

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| COURT CLAIM NO. |
| Date of Injury |

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

(Please type or Print)

| | | | |
|---------------------|------|-------|-----|
| Address of employee | City | State | Zip |
|---------------------|------|-------|-----|

| | | | |
|---------------------|------|-------|-----|
| Address of employer | City | State | Zip |
|---------------------|------|-------|-----|

Has any order determining compensability been entered? YES NO

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| Describe the treatment or services rendered |
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| Explain fully why this charge is being disputed, or why this charge should be allowed, referencing procedure codes and/or Ground Rules from the Schedule of Medical and Hospital Fees. This MUST be filled out in detail. If additional space is required, attach a separate sheet. |
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A COPY OF THE ACTUAL DISPUTED MEDICAL BILL **MUST** BE ATTACHED, TOGETHER WITH A COPY OF THE PAYOR'S EXPLANATION OF BENEFITS. The bill must include:

- Dates of Service, listed chronologically, with procedure codes and charges for services rendered;
- Notation of all payments received; and
- Explanation of unusual services or circumstances.

I declare under penalty of perjury that I have examined this request, including all statements contained herein, and to the best of my knowledge and belief, it is true, correct and complete. Further, I hereby certify that a copy of this request for administrative review, including all supporting documentation, has been mailed to each interested party. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Signed this _____ day of _____,

I HEREBY CERTIFY THAT A COPY, TOGETHER WITH ATTACHMENTS, HAS BEEN SENT TO:

Signature of Authorized Requesting Party

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| <input type="checkbox"/> Self-Insured Employer/Own Risk Group <input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Uninsured Employer |
| Address (Number & Street) |
| City State Zip Code |

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|---|
| Name of Provider |
| Address (Number & Street) |
| City State Zip Code |
| Telephone # Tax ID# |