FORM 19

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

WORKERS' COMPENSATION COURT
1915 NORTH STILES AVENUE
OKLA. CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

In re claim of:

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
Name of Provider

Please check (☑) the appropriate box

☐ **I. REQUEST FOR PAYMENT OF CHARGES FOR HEALTH OR REHABILITATION SERVICES**

☐ **II. NOTICE OF APPEAL OF ADMINISTRATIVE ORDER**

COURT CLAIM NO.
(Must be filled out)

Date of Injury

(Please type or Print)

Address of Employee (Claimant) including Number & Street	City	State	Zip Code
Address of Employer (Respondent) including Number & Street	City	State	Zip Code
Address of Provider including Number & Street	City	State	Zip Code
Provider's Telephone Number			

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.

*If the Form 19 is being filed to appeal an order issued by the Administrator of the Workers' Compensation Court, please complete **PART II ONLY.***

—PART I. REQUEST FOR PAYMENT OF CHARGES FOR HEALTH OR REHABILITATION SERVICES

1. Total expenses to date for services rendered or medicines or supplies provided to claimant $_____
2. Date charges identified above were submitted to the claimant's self-insured employer, uninsured employer or the employer's workers' compensation insurance carrier (**MUST** be completed).

_____, _____. Total Amount Received In Payment $_____.

If the dispute involves the length of treatment rendered, or relates to complex medical treatment rendered beyond the limitation of the Schedule of Medical and Hospital Fees, a narrative medical report explaining the treatment provided and the charges submitted, **must be sent to the payor. DO NOT ATTACH A COPY OF ANY BILLS OR MEDICAL REPORTS WHEN FILING THE FORM 19 WITH THE WORKERS' COMPENSATION COURT.**

—PART II. NOTICE OF APPEAL OF ADMINISTRATIVE ORDER

1. **Filed Stamped Date of Administrative Order:**_____, _____.
2. **Identify each portion of the Administrative Order which is claimed in error and how it conflicts with the Schedule of Medical and Hospital Fees:**

_____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY OF THIS FORM AND ALL RELEVANT BILLS AND MEDICAL REPORTS HAS BEEN SENT TO:

Signed this _____ day of _____, _____

_____
Signature of Provider

☐ Self-Insured Employer/Own Risk Group ☐ Insurance Carrier ☐ Uninsured Employer		
Address (Number & Street)		
City	State	Zip Code

Print or type Name of Attorney Representing Provider, if any		OBA #
Attorney Address (number & street)		
City	State	Zip Code
Telephone Number of Attorney representing Provider		

11/01

ATTENTION: The Workers' Compensation Court will not set this Form 19 for hearing unless it is attached to a Form 9, "Motion to Set for Trial" either as an original proceeding or as an appeal of an order of the Administrator of the Workers' Compensation Court.