COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
MEDICAL FEE REVIEW SECTION
1171 S. CAMERON STREET, ROOM 310
HARRISBURG, PA 17104-2501
(717) 772-1900

APPLICATION FOR FEE REVIEW PURSUANT TO SECTION 306 (F.1)

PATIENT/EMPLOYEE SOCIAL SECURITY NUMBER

___ - __ - ____

DATE OF INJURY

__ - __ - ____
MONTH DAY YEAR

507 0708

PA BWC CLAIM NUMBER (IF KNOWN)

PATIENT/EMPLOYEE

First Name

Last Name

INSURER or THIRD PARTY ADMINISTRATOR (if self insured)

Name

Address

Address

City/Town State Zip

Telephone ( ) Bureau Code

Contact

Claim # FEIN

EMPLOYER

Name

Address

Address

City/Town State Zip

County

Telephone ( ) FEIN

PROVIDER

Name

Address

Address

City/Town State Zip

Telephone ( )

Federal Tax ID Number

MC Provider # / NPI #

Specialty

Contact

PROVIDER REPRESENTATIVE or CORRESPONDENCE ADDRESS (if Other Than Above)

Name

Address

Address

City/Town State Zip

Telephone ( )

Review being requested for: ☐ **Amount of Payment** ☐ **Timeliness of Payment** ☐ **Both**

Dates of Service From (Month - Day - Year)	Dates of Service To (Month - Day - Year)	Date Bill Originally Submitted to Carrier: (Month - Day - Year)	Paid	Denied	Paid Part/ Denied Part
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(over)

PROOF OF SERVICE

I hereby certify that on _____, I sent copies of this Application for Fee Review and the supporting
DATE (Month-Day-Year)

documentation to _____
INSURER/EMPLOYER

at _____
STREET ADDRESS

_____ via
CITY/TOWN STATE ZIP CODE

_____
FIRST CLASS MAIL, OVERNIGHT MAIL, ETC.

_____ _____
SIGNATURE OF PROVIDER OR REPRESENTATIVE
(NOTE: Request will be returned if not signed and dated
DATE
(Month-Day-Year)

_____
TYPED/PRINTED NAME OF PROVIDER OR REPRESENTATIVE

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

NOTICE: STATUTE OF LIMITATIONS/TIME FOR FILING APPLICATION FOR FEE REVIEW

Act 57 of 1996 amended Section 306(f.1)(5) of the Workers' Compensation Act to require that the Application for Fee Review must be filed no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment, whichever is later.

INSTRUCTIONS

This form must be used to request medical fee review pursuant to Section 306(f.1)(5) of the Workers' Compensation Act. Your application will be returned and your request for review may not be considered until all requested documentation is provided per Sections 127.252(b) and 127.253 of the Rules and Regulations.

This form will be machine-read by the Bureau of Workers' Compensation. The red lines and boxes will "drop out" during processing so that the information typed or written (typed is preferable) on the form can be automatically "read" and used by the Bureau's computer system. Forms that do not meet Bureau requirements will be rejected.

Where to Type:
When typing a form, begin in the left most box of each set of red boxes. Use normal spacing (do not put one number per box) staying within the range of boxes. Avoid typing in the margins. Use black ink.

Where to Handwrite:
When completing a form by hand, print clearly, in black ink, placing one numeral within each box.

Dates:
Enter all dates as MMDDYYYY. For example:

TYPED

Month Day Year
04272005 -

OR

HANDWRITTEN

Month Day Year
0 4 - 2 7 - 2 0 0 5

Name/Address Areas:
When typing or writing (typed is preferable) in name and address blocks, stay within the red-lined area. For example:

First Name JOHNATHAN
Last Name JONES

OR

First Name JOHWATHAN
Last Name JONES

Auxiliary aids and services are available upon request to individuals with disabilities. *Equal Opportunity Employer/Program*