MFDR FORM 10M

Send original to:
Workers' Compensation Commission and 1 copy to Claimant/Claimant's Counsel and 1 copy to Provider

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

In re claim of:

Full Name of Injured Employee (Claimant)
Claimant's Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured
Name of Claiming Provider
Provider's Address

RESPONSE TO PROVIDER REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION

COMMISSION FILE NO. (Must be filled out)
Date of Injury

(Please Type or Print)

Address of Employee (Claimant):	Number & Street	City	State	Zip Code
Address of Employer (Respondent):	Number & Street	City	State	Zip Code

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

YES NO

_____ _____ 1. Has payment been refused?

2. Grounds for the refusal of payment?
   - _____ _____ a. necessity of treatment rendered.
   - _____ _____ b. unauthorized physician.
   - _____ _____ c. denial of compensability of the claimant's accidental injury, cumulative trauma or occupational disease or illness.
   - _____ _____ d. other, including affirmative defenses (explain) _____

Administrative Workers' Compensation Act, 85A O.S. § 6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

_____ _____ 3. Provide a position statement of the disputed issue(s) which includes: **(a)** the respondent's reasoning for why the disputed fees should not be paid, **(b)** a discussion of how the Administrative Workers' Compensation Act (AWCA), Workers' Compensation Commission rules, and/or the Oklahoma workers' compensation fee schedule impacts the disputed issue(s), including reference to the specific general instruction, ground rule or other provision of the Oklahoma workers' compensation fee schedule serving as the basis for the respondent's position, and **(c)** a discussion of how the submitted documentation supports the respondent's position for each disputed fee issue. (ATTACH ADDITIONAL PAGES IF NEEDED.)___

_____ _____ 4. Was provider notified of refusal of payment within 45 days?

_____ _____ 5. Is there is a final decision regarding ☐ compensability ☐ extent of injury ☐ liability and/or ☐ medical necessity? (Check applicable options.)
Date of order(s) _____

_____ _____ 6. Has the claimant's request for benefits been resolved by Joint Petition Settlement of the parties?
Date of Settlement _____

_____ _____ 7. Has claimant been provided Temporary Total Disability benefits? Date TTD benefits provided: _____to_____

8. List the names of all witnesses who may be called by respondent at hearing: (Attach additional pages if needed.) _____

9. List all exhibits to be introduced at hearing: (Attach additional pages if needed.) _____

ATTENTION: Send a copy of the MFDR Form 10M and the following to the PROVIDER: (1) a paper copy of all initial and appeal explanation of benefits (EOB) related to the dispute, as originally submitted to the health care provider, related to the health care in dispute not submitted by the health care provider, or a statement certifying that the respondent did not receive the health care provider s disputed billing before the MFDR Form 19 dispute request (2) a paper copy of all medical bills related to the dispute, if different from that originally submitted to the payor for reimbursement and (3) a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the health care provider. *DO NOT ATTACH ANY SUCH RECORDS OR DOCUMENTATION TO THE MFDR FORM 10M WHEN THE FORM IS FILED WITH THE COMMISSION.*

For assistance and general information about completing and submitting this form, contact the Workers Compensation Commission's Counselor Division, (405) 522 5308 or In State Toll Free (855) 291 3612.

The undersigned declare under PENALTY OF PERJURY that they have examined all statements contained herein, and to their best knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Signed this _____ day of_____,_____.

THE RESPONDENT/INSURER HEREBY CERTIFY THAT A COPY OF THIS FORM AND ALL RELEVANT REPORTS AND DOCUMENTATION HAVE BEEN SENT TO:

☐ **Claimant** ☐ **Health/Rehabilitation Provider**
Address (Number & Street)
City **State** **Zip Code**

Signature of ☐ Respondent ☐ Insurer ☐ Counsel for Respondent/Insurer
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Responding Party
Print or type name of Attorney **OBA #**

Revised 4-18-18