MFDR FORM 19

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

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

THIS SPACE FOR COMMISSION USE ONLY

PROVIDER REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION

In re claim of:

Name of Provider **(Claimant)**

Full Name of Injured Employee

Injured employee's SSN (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

☑ Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-19. **(Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior Information.)**

COMMISSION FILE NO.
(To be completed by Commission staff only)

Date of Injury

(Please type or print)

Address of Provider **(Claimant)** Including Number & Street | City | State | Zip

Provider's Telephone Number

Address of Employer (Respondent) Including Number & Street | City | State | Zip

Address of Injured Employee Including Number & Street | City | State | Zip

If Known, Underlying WCC Claim Number for Injured Employee

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.

REQUEST FOR PAYMENT OF CHARGES FOR HEALTH OR REHABILITATION SERVICES

1. Date(s) of the service(s) in dispute: _____
2. Place of service: _____
3. Treatment or service code(s) in dispute: _____
4. Amount billed by the provider for the treatment(s) or service(s) in dispute: $_____
5. Date charges identified in Paragraph 4 were submitted to the workers' compensation payor. (**MUST be completed.**) _____
6. Amount paid by the workers' compensation payor for the treatment(s) or service(s) in dispute: $_____
7. Disputed amount for each treatment or service in dispute (attach additional pages if needed): _____

_____

8. Is there is a final decision regarding ☐ compensability ☐ extent of injury ☐ liability and/or ☐ medical necessity? (Check applicable options.)
9. Provide a position statement of the disputed issue(s) which includes: **(a)** the provider's reasoning for why the disputed fees should 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 fee issues, including reference to the specific general instruction, ground rule or other provision of the fee shcedule serving as the basis for the requested reimbursement; and (**c)** a discussion of how the submitted documentation supports the provider's position for each disputed fee issue. (ATTACH ADDITIONAL PAGES IF NEEDED.) _____

_____

ATTENTION: The Workers' Compensation Commission will NOT set this MFDR Form 19 for hearing unless it is attached to a CC Form 9, Request for Hearing . Send a copy of the CC Form 9, MFDR Form 19 and the following to the workers' compensation PAYOR: (1) a paper copy of all medical bills related to the dispute, as originally submitted to the payor (2) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider (3) a copy of all applicable medical records related to the date(s) of service in the dispute and (4) any other documentation that the provider deems applicable to the medical fee dispute. *DO NOT ATTACH ANY SUCH RECORDS OR DOCUMENTATION TO THE MFDR FORM 19 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.

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 punishable by imprisonment, a fine or both.

Signed this _____ day of _____, _____

I HEREBY CERTIFY THAT A COPY OF THIS FORM AND ALL RELEVANT RECORDS AND DOCUMENTATION, INCLUDING BILLS AND APPLICABLE MEDICAL RECORDS, HAVE BEEN SENT TO:

_____
Signature of Provider

Name of ☐ 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, if any

Revised 5-1-2023