# Department of Workforce Development

**Worker’s Compensation Division**

201 E. Washington Ave., Rm. C100

P.O. Box 7901

Madison, WI 53707

Telephone: (608) 266-1340

Fax: (608) 260-3143

https://dwd.wisconsin.gov/wc

e-mail: wchealthcostdispute@dwd.wisconsin.gov

**REASONABLENESS OF FEE**

**DISPUTE RESOLUTION REQUEST**

**Direct all inquiries to the Health Cost Dispute Unit.**

**Fax application packets to 1-608-260-3143 or mail to the Department's P.O. Box address.**

**INSTRUCTIONS: Complete Sections 1-5. A complete application includes form WKC-9498, health claim forms, medical notes, and all correspondence related to the charges in dispute.**

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

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| **SECTION 1 - Provide the dates requested in paragraphs A & B in the column at right** | **DATE** |
| A. Date health care provider first billed insurer or self-insurer.NOTE: The provider has 6 months to file a dispute resolution request with the department from the date the insurer or self-insurer first disputes the reasonableness of the fee charged. |  |
| B. Date insurer or self-insurer first disputes the reasonableness of the fee charged.NOTE: If this date is not within 30 days of the billing date shown in Section 1A, the insurer shall compute and pay interest from this date if the provider prevails. |  |

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| **SECTION 2** | **YES** | **NO** |
| A. In disputing the fees listed in Section 4, did the insurer state it was using a database certified by the department? | **[ ]**  | **[ ]**  |
| B. Is the provider alleging that a fee greater than the formula amount from a certified database is justified because the service provided in this case was more difficult or complicated to provide than the usual case? | **[ ]**  | **[ ]**  |
| C. If the answer to B is yes, at least 20 days prior to filing this dispute, did the provider explain to the insurer the reason for the higher fee? | **[ ]**  | **[ ]**  |
| D. If the answer to C is yes, did the insurer respond to the explanation? | **[ ]**  | **[ ]**  |
| E. Is the provider continuing to treat this patient for the injury? | **[ ]**  | **[ ]**  |

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| **SECTION 3** | **YES** | **NO** |
| 1. **As required by law**, I am enclosing all correspondence and medical records relating to this dispute. | **[ ]**  | **[ ]**  |
| 1. I am including the insurer's or self-insurer's initial notice refusing to pay.
 | **[ ]**  | **[ ]**  |
| 1. I am including my written response explaining to the insurer why the fee was justified.
 | **[ ]**  | **[ ]**  |
| 2. **As required by law,** I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the same time I filed this request with the department.  | **[ ]**  | **[ ]**  |

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| **Dispute Resolution Request Information** |
| Provider or representative name Date            |
| Telephone number for questions regarding this dispute resolution request      |
| Fax number for Department use when returning applications to provider for completion/correction      |

PLEASE CONTINUE TO PROVIDE INFORMATION ON THE REVERSE SIDE

WKC-9498-E (R. 03/2024)

|  |  |  |  |
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| **SECTION 4** | **NAME** | **Mailing Address for****Dispute Correspondence** | Injury Date      |
| Employee/Patient |  |       |
| Employer (at the timeof injury) |       |       | Social Security Number\*      |
| Insurer or Self-Insurer |       |       | Certified Database Used by the Insurer      |
| Health Care Provider |       |       |

\*Provision of the Social Security Number (SSN) is voluntary; not providing it could result in an information processing delay.

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| **SECTION 5** | Treatment Zip Code:  | The provider's fee is based upon the **zip code** where the service was provided. |
| **CPT, HCPCS II,****DRG CODE**  | **CPT****MODIFIER** | **NUMBER OF****TREATMENTS**  | **NUMBER** **OF UNITS** | **SERVICE DATES** | **AMOUNTS ($)** |
|  |  |  |  | **FROM** | **TO** | **CHARGED** | **PAID^** | **DISPUTED** |
|       |       |       |       |       |       |       |       | 0.00 |
|       |       |       |       |       |       |       |       | 0.00 |
|       |       |       |       |       |       |       |       | 0.00 |
|       |       |       |       |       |       |       |       | 0.00 |
|       |       |       |       |       |       |       |       | 0.00 |
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|       |       |       |       |       |       |       |       | 0.00 |
|       |       |       |       |       |       |       |       | 0.00 |
|  |  |  |  |  | **TOTAL** | **$****0.00** | **$****0.00** | **$ 0.00** |

**^PAID amount includes payments received from insurer and any accepted deductions - multiple procedure, modifiers, etc. DISPUTED amount must equal CHARGED amount minus PAID amount.**