NECESSITY OF TREATMENT
DISPUTE RESOLUTION REQUEST

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 264-6819
Fax: (608) 260-3143
https://dwd.wisconsin.gov/wc
e-mail: wchealthcostdispute@dwd.wisconsin.gov

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 Section 1 OR Section 2, AND sections 3,4, & 5. A complete application includes the application form, health claim forms, medical notes, and all correspondence related to the charges in dispute.

You are the RESPONDENT in this matter.

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.

SECTION 1. REQUEST FOR AN INDEPENDENT REVIEW

Complete section 1 if the insurer or self-insurer has denied payment because the treatment was considered unnecessary to cure or relieve the effects of the conceded work injury. Complete sections 3, 4, and 5.

1) On _____, I received notice within 60 days of submitting the bill for payment from the insurer or self-insurer refusing to pay for the treatment specified in Section 5 because it was not necessary.

2) This is the first necessity of treatment dispute resolution request I have submitted to the department.
☐ Yes ☐ No

SECTION 2. REQUEST FOR A DEFAULT ORDER: LATE NOTICE - OVER 60 DAYS

Complete section 2 if you have not received payment or denial from the insurer or self-insurer within 60 days of the date the bill was submitted. Complete sections 3, 4, & 5.

A default order may be requested only if a review is not requested in SECTION 1 above.

On (date/s) , I submitted my bill to the insurer or self-insurer listed in Section 4 and I was not notified within 60 days that liability or the extent of liability is in dispute, or the insurer or self-insurer failed to pay the bill or to provide me with notice within 60 days of the date I submitted my initial bill explaining the reason why the treatment was not necessary.

SECTION 3.	**YES**	**NO**
1. As required by law, I am enclosing copies of all correspondence and medical records relating to this dispute. This includes:	☐	☐
a. The insurer's or self-insurer's initial notice refusing to pay.	☐	☐
b. My written response explaining to the insurer why the treatment was necessary.	☐	☐
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 time I filed this request with the department.	☐	☐

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

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient		
Employer (at the time of injury)		
Insurer or Self-Insurer		
Health Care Provider		

Injury Date:	Employee Social Security Number*:
Are you continuing to treat this patient for the injury? ☐ Yes ☐ No	

*Provision of the Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

SECTION 5.	DATES		AMOUNT ($)
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED
		TOTALS	

<u>If an independent review is requested</u>, the individual health care practitioner whose treatment or order of treatment is the subject of this dispute per s. DWD 80.73(2)(d), Wis. Admin. Code <u>must sign and date this form below.</u> This must be a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist. <u>If a default order is requested</u>, this signature is not necessary.

Practitioner Name (print or type)	WI License Number

Practitioner Signature: _____ Date Signed: _____