REASONABLENESS OF FEE DISPUTE RESOLUTION

DISPUTE ID: EMPLOYEE: SAMPLE SAMPLE SAMPLE SIMPLES
INJURY DATE: EMPLOYER: SAMPLE EMPLOYER INC

Treatment Dates: From: Through:

On, submitted to the Department a reasonableness of fee dispute resolution request for dates of treatment, through, in the amount of. The provider requested that the Department determine whether or not a fee is reasonable under Wis. Stat. § 102.16(2) and Wis. Admin. Code DWD § 80.72.

The Department sent notice of the health cost dispute resolution request to Test Insurer 2. The notice stated that the insurer had 20 days to file an answer with the Department.

Test Insurer 2 responded indicating that payment was made after the filing of the health cost dispute resolution request.

Therefore, is to notify the Department in writing, with a copy to the insurer, whether satisfactory payment was received. The notice can be mailed to the PO Box address or faxed to the Health Cost Dispute Unit's fax number, which are listed above. Failure to respond within 30 days of the date of this letter may result in a determination that this dispute has been resolved and a dismissal order may be issued.

If you need further information, please contact the Health Cost Dispute Unit at (608) 266-1340.

Health Cost Dispute Unit
Division of Worker's Compensation

GL115 (R.06/2019)

Copy sent to:
TEST INSURER 2
C/O TEST INSURER 2
RM C100
201 E WASHINGTON AVE
MADISON WI 53703