FORM 10M

Send original to
Court of Existing Claims and 1 copy to
Claimant/Claimant's Counsel and 1 copy to
Health/Rehabilitation Provider

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLA.CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

In re claim of:

Full Name of Injured Employee (Claimant)
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured
Name of Claiming Provider
Provider's Address

RESPONSE TO REQUEST FOR PAYMENT OF CHARGES FOR HEALTH OR REHABILITATION SERVICES

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

(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 address certain workers' compensation disputes.
For information, call (918) 581-2714.

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 or occupational disease.
_____	_____	d. other, including affirmative defenses (explain)_____
_____	_____	3. Was provider notified of refusal of payment within 45 days?
_____	_____	4. Has an order from the Court of Existing Claims been issued regarding the compensability of the claimant's request for compensation? Date of order _____
_____	_____	5. Has the claimant's request for benefits been resolved by Settlement or Agreement of the parties? Date of Settlement or Agreement _____
_____	_____	6. Has claimant been provided Temporary Total Disability benefits? Date TTD benefits provided: _____to_____

7. List all other medical providers in this claim which are in dispute: Medical/Rehabilitation Provider_____
_____
8. List the names of all witnesses who may be called by respondent at trial: _____
_____
9. List all exhibits to be introduced at trial: _____
_____

If the dispute involves the length or necessity of treatment rendered, or relates to complex medical treatment rendered beyond applicable treatment guidelines, a narrative medical report opposing the treatment provided and/or the charges submitted must be sent to the health/rehabilitation provider. Do <u>NOT</u> attach a copy of the medical report when filing the Form 10M with the Court of Existing Claims.

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.

Signed this_____day of_____,_____.

I HEREBY CERTIFY THAT A COPY OF THIS FORM AND ALL RELEVANT MEDICAL REPORTS HAVE BEEN SENT TO:

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

Signature of Responding Party		
Address (Number & Street)		
City	**State**	**Zip Code**
Telephone # of Responding Party		
Print or type name of Attorney		**OBA #**

Rev. 06/24/2015