FORM 18

Send original to
Court of Existing Claims and 1 copy to:
Insurance Carrier, Self-Insured Employer/Own Risk Group or Uninsured Employer

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)
Employee'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

REQUEST FOR COURT ADMINISTRATOR REVIEW OF DISPUTED MEDICAL CHARGES

WCC FILE NO.
Date of Injury

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

(Please Type or Print)

Address of employee	City	State	Zip
Address of employer	City	State	Zip

Has any order determining compensability been entered? ☐ YES ☐ NO

Describe the treatment or services rendered.

Explain fully why this charge is being disputed, or why this charge should be allowed, referencing procedure codes and/or Ground Rules from the Schedule of Medical and Hospital Fees. This **MUST** be filled out in detail. If additional space is required, attach a separate sheet.

A COPY OF THE ACTUAL DISPUTED MEDICAL BILL **MUST** BE ATTACHED, TOGETHER WITH A COPY OF THE PAYOR'S EXPLANATION OF BENEFITS. The bill must include:

1. Dates of Service, listed chronologically, with procedure codes and charges for services rendered;
2. Notation of all payments received; and
3. Explanation of unusual services or circumstances.

I declare under penalty of perjury that I have examined this request, including all statements contained herein, and to the best of my knowledge and belief, it is true, correct and complete. Further, I hereby certify that a copy of this request for administrative review, including all supporting documentation, has been mailed to each interested party. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Signed this _____day of_____,_____

_____
Signature of Authorized Requesting Party

I HEREBY CERTIFY THAT A COPY, TOGETHER WITH ATTACHMENTS, HAS BEEN SENT TO:

☐ Self-Insured Employer/Own Risk Group ☐ Insurance Carrier ☐ Uninsured Employer		**Name of Provider**
Address (Number & Street)		**Address (Number & Street)**
City	**State**	**Zip Code**
		City **State** **Zip Code**
		Telephone # **Tax ID #**

Rev. 06/24/2015