REASONABLENESS OF FEE DISPUTE RESOLUTION REQUEST

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
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

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.

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.	

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?	☐	☐

SECTION 3	YES	NO
1. **As required by law**, I am enclosing all correspondence and medical records relating to this dispute.	☐	☐
A. I am including the insurer's or self-insurer's initial notice refusing to pay.	☐	☐
B. 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.	☐	☐

Dispute Resolution Request Information	
Provider or representative name	Date
Telephone number and/or email for questions regarding this dispute resolution request	
Fax number or email for returning applications to provider for completion/correction	

PLEASE CONTINUE TO PROVIDE INFORMATION ON THE REVERSE SIDE

SECTION 4	NAME	Mailing Address for Dispute Correspondence	Injury Date
Employee/Patient			
Employer (at the time of 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.

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
								0.00
								0.00
								0.00
								0.00
					TOTAL	$0.00	$0.00	$ 0.00

^DISPUTED amount must equal CHARGED amount minus PAID amount.