Reset Form

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State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Bill Review

Print Form

Medical provider information and Bill Information (Completion of this section is required)

Injured worker first name _____ Injured worker last name _____

Workers' Date of Birth _____ Claim number _____ Date the 2d bill Review completed: _____

What fee schedule applies? _____ Provider Type: _____

NPI number, if applicable _____ Is the liability for the bill being denied ? _____

_____
Provider Name (Please leave blank spaces between numbers, names or words)

_____
Provider Street Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
Provider City State Provider Zip Code

Employer, Insurance Carrier or Claims Administrator Information (Completion of this section is required)

_____
Employer Name (Please leave blank spaces between numbers, names or words)

_____
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

_____
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
Insurance Carrier City State Zip Code

Claims Administrator Information (if known and if applicable)

_____
Claims Administrator Name (Please leave blank spaces between numbers, names or words)

_____
Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
Claims Administrator City State Zip Code

Briefly describe the reason stated on the explanation of review why payment was denied or reduced

Date: _____
MM/DD/YYYY

_____
Signature

File this Application at the following address: Division of Workers' Compensation
P.O. Box 7788999
Sacramento, Ca. 99999

Proof of Service By Mail

I declare that:

I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years, my business or residence address is:

On _____ , I served the attached *Application for Independent Bill Review* in this case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail, addressed as follows:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on:

Date: _____ at _____ , California.
City

Type or print name _____

Signature _____