Reset Form

DRAFT

State of California
Department of Industrial Relations
Division of Workers' Compensation
Request for Second Bill Review

Print Form

Identify the Bill for which second review is requested (Completion of this section is required):

Injured worker first name _____ Injured worker last name _____

_____ _____

Date of the EOR Claims Administrator Name (*Please use the administrators uniform assigned name.)*

If this review falls under the OMFS, place the bill submitter's Identifier here _____ .

If this review is under the medical/ legal fee schedule, place the claim number here _____ .

_____

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

Items for which second review is requested (Completion of this section is required):

Date of the Service	Service and description	Amount Billed	Amount Paid	Amount Demanded

State the reason why the additional amount is requested

_____

Date of the Service	Service and description	Amount Billed	Amount Paid	Amount Demanded

State the reason why the additional amount is requested

_____

Date of the Service	Service and description	Amount Billed	Amount Paid	Amount Demanded

State the reason why the additional amount is requested

_____

Date of the Service	Service and description	Amount Billed	Amount Paid	Amount Demanded

State the reason why the additional amount is requested

_____

Date: _____ _____

MM/DD/YYYY Signature

Attach additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.