

APPLICATION FOR MEDIATION OR HEARING – FORM B

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909

I hereby certify that we have complied with Rules 1301 through 1305 and Parts 9 and 10 of the Workers' Compensation Health Care Services Rules

Submitted on behalf of: Health Care Provider Insurance Company Self-Insured Employer

EMPLOYEE IDENTIFICATION

1. Employee Name (Last, First, MI)		2. Social Security Number		3. Date of Birth	4. Date of Injury	
5. Street Address		6. City		7. State	8. ZIP Code	9. County of Injury

EMPLOYER IDENTIFICATION

10. Employer Name			11. Federal I.D. Number		
12. Street Address		13. City		14. State	15. ZIP Code
16. Contact Person			17. Telephone Number		

CARRIER IDENTIFICATION

18. Carrier or Self-Insured Name			19. NAIC or Self-Insured Number		
20. Street Address		21. City		22. State	23. ZIP Code
24. Claim Handler		25. Claim Number		26. Telephone Number	

HEALTH CARE PROVIDER IDENTIFICATION

27. Provider Name				28. License, Registration, or Certification Number	
29. Street Address		30. City		31. State	32. ZIP Code
33. Date of Service	Amount of Bill	Date of 1 st Billing	Date of 2 nd Billing	Late Fee Requested	Reason for Filing (see codes on reverse)
34. <input type="checkbox"/> If the worker involved in this case is currently being denied treatment as a result of this dispute, check the box on the left and provide a description of the needed treatment that is being denied in the box on the back.					
35. <input type="checkbox"/> If the carrier is currently paying for medical benefits pursuant to an order and this is a petition to stop such payment, check the box on the left and attach a copy of the order.					

By signing this form, I certify that the information included on this form is true, correct and complete to the best of my knowledge. I understand that making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

36. Applicant Name		37. Telephone Number		38. Applicant Email Address	
39. Applicant Signature				40. Date	
41. Name of Attorney (if applicable)		42. Attorney I.D.	43. Attorney Telephone Number		44. Attorney Signature

Reason for Filing Codes (last column in Line 33)

- A. No response to the bill
- B. Not paid in 30 days per R418.10116 (2)
- C. No carrier response to provider's request for reconsideration
- D. Incorrect payment, not resolved by provider's request for reconsideration
- E. Claim in litigation, medical services remain unpaid
- F. Carrier disputed utilization of medical services
- G. Carrier requests recovery of payment
- H. No report of injury on file with carrier
- I. Other

Additional information regarding Reason for Filing:

This form is only to be submitted in cases involving workers' compensation health care disputes between carriers (insurance companies, self-insured employers, or group funds) and health care providers.

The completed application must be mailed to the Workers' Disability Compensation Agency, PO Box 30016, Lansing, MI 48909, with a completed copy mailed to the carrier. **There is no need to send additional documentation to have the teleconference scheduled.**

You must complete this form properly to avoid any delay in processing.

All parties involved in this case will be served a copy of the Form 104B and a teleconference will be scheduled. You can obtain more information or forms by contacting the Workers' Disability Compensation Agency at 1-888-396-5041.

This application is provided in accordance with Part 13, R 418.101303 of the Workers' Compensation Health Care Services Rules.

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.