



APPLICATION FOR ADJUSTMENT OF CLAIM FOR PROVIDER FEE

State Form 18487 (R5 / 4-09)

WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204-2753

- INSTRUCTIONS:**
1. The applicant must file an original and four (4) copies of this application for it to be processed.
 2. Mail to the Worker's Compensation Board at the above address.

FOR STATE USE ONLY

Application number

PLAINTIFF vs DEFENDANT			
Name of plaintiff (<i>provider</i>)		Name of defendant (<i>employer</i>)	
Address (<i>number and street</i>)		Address (<i>number and street</i>)	
City, state, and ZIP code		City, state, and ZIP code	
Telephone number ()	Federal identification number	Telephone number ()	Federal identification number
Name of attorney (<i>must complete</i>)		Name of insurance carrier	Insurance claim number
Address (<i>number and street</i>)		Address (<i>number and street</i>)	
City, state, and ZIP code		City, state, and ZIP code	
Telephone number ()	E-mail address	Name of adjuster	
Attorney number		Telephone number ()	E-mail address
		Billing review company	
		Name of reviewer	
		Telephone number ()	E-mail address

Must check one

Total Billing (*no payment received*)

Balance Billing (*partial payment received*)

THE PLAINTIFF RESPECTFULLY REPRESENTS TO THE BOARD AS FOLLOWS:

That the defendants, as employer and employer's compensation insurance carrier, owe and are indebted to the plaintiff on account in the sum of _____ dollars for provider's fee and supplies in the treatment of the injuries of _____
Name of injured person
 incurred as a result of an injury / illness arising out of and in the course of the employment with the defendant employer, on the _____ day of _____, 20____, in the county of _____.

Latest date of service (*month, day, year*): _____

That said services were rendered as follows (*check one*):

In an emergency

The employer failed to provide such service

The employee was in need of timely services provided

Employer or insurance carrier approved such services

Provider first requested payment for said services on (*month, day, year*): _____

Provider demands payment by (*month, day, year*): _____

Wherefore the plaintiff prays to the Board to find against the defendant on said account the sum of \$ _____.

Signature of plaintiff	Date signed (<i>month, day, year</i>)
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