REQUEST FOR ENFORCEMENT OF ADMINISTRATIVE DECISION

Attn: James Rankin, Senior Attorney
Mississippi Workers' Compensation Commission

Date:

RESPONSE FROM PAYER: (i.e. Partial payment)

Date of MWCC Administrative Decision: ____________ MWCC-CC #: _____________

Amount of Decision: :________ ___ (Amount Owed)

Provider:

Patient ID#:

Claimant:

Claim #:

Date(s) of Service:

Payer:

Payer Address:

Service Type: (i.e.: Inpatient - DRG 432)

Total Charges:

Provider Bill Date/Date Received by Payer:

MWCC Fee Schedule Allowable: $_____________

1st Payment Amount: $ ___________ Payment Date:__________

2nd Payment Amount: $ __________ Payment Date:__________

Date of Last Written Notification by Provider to Payer:

Date of Last Telephonic Communication by Provider to Payer:

MWCC Fee Schedule Allowable Amount Due: $ _____________

1.5% Interest and 10% Penalty Amount Due, if applicable: $___________ thru __/__/___

TOTAL AMOUNT DUE: $______________

CC: (Payer)