Mississippi Workers' Compensation Commission—Request for Resolution of Dispute

Mississippi Workers' Compensation Commission

Request for Resolution of Dispute

Instructions for Use

Please complete this form and file it with the MWCC along with the required supporting documents to the following address:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P.O. Box 5300
Jackson, MS 39296-5300

THE OPPOSING PARTY MUST BE SERVED WITH A COPY OF THE REQUEST FOR RESOLUTION OF DISPUTE AND ITS CONTENTS BY CERTIFIED MAIL.

Dispute submitted by: ❑ Provider ❑ Payer ❑ Other _____

Provider Information

Name _____

Address _____

Contact Person _____

Telephone # _____ E-mail Address _____

Payer Information

Carrier/Self Insured Name _____

Address _____

Telephone # _____ E-mail Address _____

Insurance Company/Third-Party Administrator _____

Injured Worker's Information

Name _____

Address _____

Claim # _____ Date(s) of Service _____

Employer _____ Date of Injury _____

Detailed Explanation of the Dispute(s)

_____

_____

_____

_____

Please attach all supporting documents applicable regarding this Request for Resolution of Dispute:

❑ Original Bill ❑ Certified Mail Receipt ❑ Prior Authorization
❑ EOB(s)/EOR(s) ❑ Medical Records/Invoice(s) ❑ Appeal(s)
❑ Other pertinent information for review of this claim
❑ Documentation to substantiate the reconsideration of the original bill(s) submitted
❑ Supporting documentation and communication/correspondence from other party

Do Not Write Below This Line

Date Received at MWCC _____

MWCC-CC # _____

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