**State of South Carolina**



TEL: (803) 737-5700

www.wcc.sc.gov

1333 Main Street, 5th Floor

P.O. Box 1715

Columbia, S.C. 29202-1715

**Workers’ Compensation Commission**

**INITIAL MEDICAL BILL DISPUTE FORM**

**Date:**

**Person requesting Medical Bill Review/Dispute**

**Name:**

**Email Address:** **Telephone:** **WCC # (if available):** **Carrier Claim #:**

**Patient Information**

**Patient Name**

**Prefix:** **First Name:** **Middle Initial:** **Last Name:** **Suffix:**

**Last 5 digits of Social Security Number:**

**MEDICAL PROVIDER INFORMATION**

**Name of Provider:**

**Provider Mailing Address:**

**City, State, Zip:**

**Provider Contact Name:**

**Provider Contact Email Address:**

**Provider Contact Telephone:**

**Provider Contact Supervisor Name:**

**Provider Contact Supervisor Email Address:**

**Provider Contact Supervisor Telephone:**

**EMPLOYER INFORMATION**

**Employer Name:**

**Employer Mailing Address:**

**City, State, Zip:**

**Employer Contact Name:**

**Employer Contact Email Address:**

**Employer Contact Telephone:**

**INSURANCE CARRIER INFORMATION**

**Carrier Name:**

**Carrier Mailing Address:**

**City, State, Zip:**

**Carrier Contact Name:**

**Carrier Contact Email Address:**

**Carrier Contact Telephone:**

**THIRD PARTY ADMINISTRATOR (TPA)**

**TPA Contact Name:**

**TPA Contact Email:**

**TPA Contact Telephone:**

**CASE INFORMATION**

**Dates of Service (mm/dd/yyyy – may enter multiple dates):**

**Date of Injury (DOI) (mm/dd/yyyy):**

**First Bill Date (mm/dd/yyyy):**

**2nd Notice Date (mm/dd/yyyy – must be at least 30 days after first bill date):**

**Employer/Carrier/TPA response date (mm/dd/yyyy) – must be after first bill date and up to 30 days after second notice:**

**REASON FOR THE DISPUTE**

**Instructions:**

This form and the following attachments should be submitted via **secure** email to the Medical Services Division at MBDispute@wcc.sc.gov The document file name of attachments should include the patient’s last name and a description of the document is (i.e., first bill, second notice, or EOB), date of injury (i.e., yyyymmdd).

[ ]  **INITIAL MEDICAL BILL DISPUTE FORM (document file name example: lname\_MBD\_yyyymmdd.pdf)**

[ ]  **First Bill – (document file name example: lname\_First\_Bill\_yyyymmdd.pdf)**

[ ]  **Second Notice – (document file name example: lname\_ Second\_Notice\_yyyymmdd.pdf)**

[ ]  **EOB – (document file name example: lname\_EOB\_yyyymmdd.pdf)**

[ ]  **Supplemental documentation – (document file name example:
 lname\_Additional\_Correspondence\_yyyymmdd.pdf) (if applicable)**

[ ]  **Provider/Carrier Authorization:** [ ]  **verbal** [ ]  **Written (document file name example: lname\_authorization\_yyyymmdd.pdf)**

Attachments: Attachments must be in .pdf format (when creating your .pdf, please create as black and white and condensed version of .pdf to reduce the size of the attachments. The size limitation for secure mail attachments is 5MB).

If, following a review of the submitted information, the Medical Services Division determines that the submitted petition is complete and the issue presented is within the regulatory purview of the Medical Services Division to review, the Medical Services Division shall notify the Employer’s Representative of the petition/dispute through a “Notice of Dispute” (with copy to the Provider) and request that, within 30 days of such notification, the Employer’s Representative provide documentation supporting its denial or modification of payment to the Provider. Within 21 days of the earlier of the close of the 30 day response period or receipt of the Employer’s Representative’s documentation, the SCWCC Medical Service Division shall make determination concerning the petition/dispute. Per SCWCC Regulations, the decision of the Medical Services Division shall be final.