CLAIM FOR MEDICAL SERVICES

INSTRUCTIONS:This form is to be used to submit a claim for unpaid medical services pursuant to COMAR 14.09.08.06. The CMS 1500 and all relevant correspondence must be attached to this form. IF THIS CLAIM INCLUDES MULTIPLE DATES OF SERVICE, YOU MUST INDICATE ON THE ACCOMPANYING CMS 1500 THE AMOUNTS OF ANY PAYMENTS YOU HAVE RECEIVED AND INCLUDE A COPY OF THE RELEVANT EOB.

Claimant: WCC Claim No:

Date of Accident:

Claimant Address:

Employer:

Employer Address:

Insurer:

Insurer Address:

Healthcare Provider:

Healthcare Provider Address:

I hereby certify that the attached bill for , for services rendered to the above-named Claimant on was sent to the above-named Employer/Insurer in compliance with COMAR 14.09.08.06 on and that

☐ No payment has been received. ☐ Payment has been refused. ☐ Partial payment has been received.

Based upon the foregoing, I hereby request that the Commission issue an Order that the bill be paid.

Signature of Physician or Hospital Representative Date

Telephone Number

CERTIFICATION OF SERVICE

I HEREBY CERTIFY that on this day of , , service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

Signature Date

ACTION OF MEDICAL DEPARTMENT ON THE ABOVE CLAIM

APPROVED **APPROVED PER FEE GUIDE** **DISAPPROVED**

Date of Service: _____ **Amount Approved:** _____ **Amount Paid:** _____ **Amount Due:** _____

CLICK HERE TO CLEAR THE FORM