APPLICATION FOR ADJUSTMENT OF CLAIM FOR PROVIDER FEE

State Form 18487 (R4 / 9-06)

FOR STATE USE ONLY
Application number

INDIANA WORKER'S COMPENSATION BOARD
402 W. Washington St., Rm. W196
Indianapolis, IN 46204-2753

File original and four (4) copies.

PLAINTIFF vs DEFENDANT		
Name of plaintiff (*provider*)		Name of defendant (*employer*)
Address (*number and street*)		Address (*number and street*)
City, state, and ZIP code		City, state, and ZIP code
Telephone number of plaintiff ( )		Telephone number of defendant ( )
Name of attorney (*must complete*)	**vs**	Name of insurance carrier
Address (*number and street*)		Address (*number and street*)
City, state, and ZIP code		City, state, and ZIP code
Telephone number of attorney ( )		Telephone number of insurance carrier ( )
Attorney number		

Must check one

☐ **Total Billing** (*no payment received*)   ☐ **Balance Billing** (*partial payment received*)

INJURED PERSON	
Name of injured person	Date of birth (*month, day, year*)
Address (*number and street, city state, and ZIP code*)	

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 for the above-named 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 _________________________________.

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 justified in obtaining such service
☐ Employer or insurance carrier approved such service
Name: _____________________________________ Title / Position: ___________________________________

Wheretofore the plaintiff prays to the Board to find against the defendant on said account the sum of $ _________________.

Signature of plaintiff	Date signed (*month, day, year*)
Signature of attorney	Date signed (*month, day, year*)

This form cannot be processed unless filled out completely.
Must attach copy of billing.