Print Reset

PROVIDER'S REQUEST FOR RECONSIDERATION

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
Health Care Services
PO Box 30016, Lansing, MI 48909

Provider Name		
Address		
City	State	ZIP Code
Social Security/FEIN Number*		
Patient Account Number		

Employee Name		
Street Address		
City	State	ZIP Code
Social Security Number*		
Date of Bill	Date of Injury	

Carrier Name		Telephone Number	
Address	City	State	ZIP Code
Employer Name		Claim Number	

Date(s) of Service		
Charge	Payment	Requested Amount
$	$	$

Reasons for Reconsideration (detailed statement)

Documents Attached:

☐ WC-739 ☐ Requested Report ☐ Office Notes ☐ Bill

Contact Person	Telephone Number	Date

*Protected information to be used for identification purposes.

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.