Medical Fee Schedule Dispute Response Form

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Dispute Response

Name of Responding Party

Title

Mailing Address

Email Address

Primary Phone

Dispute Information

Please provide a detailed response to the dispute:

What actions have you taken to resolve this dispute? (include person(s) you spoke with and dates if available)

Please attach the three required supporting documents that are applicable in your dispute:

- Original and Resubmitted Bill(s)
- Explanation of Reimbursement/Benefit
- Supporting Documentation

☐ Correspondence and/or Specific Information Regarding the Dispute (Optional - Check box if attached)

This Dispute Resolution process shall be subject to the prompt payment or limitation of claims provisions of Va. Code Section 65.2-605.1.