Print Reset

Office of Workers' Compensation Programs (OWCP)

Fee Schedule Appeal Request Form

Program Name: Select *

TCN: * (Min 17 - Max 18 digits)

OWCP Provider ID: * (9 digits)

Claimant Case ID: (Min 3 and Max 16 characters)

Claimant Name: (First Name and Last Name)

Reason for Fee Schedule Appeal (check all that apply)**:**

- ☐ The procedure performed was incorrectly identified by the original code
- ☐ The presence of a severe or concomitant medical condition made treatment especially difficult
- ☐ The provider possessed unusual qualifications

Explanation for Fee Schedule Appeal:

INSTRUCTIONS:

A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by the Director may, within 30 days, request reconsideration of the fee determination. The provider should make such a request to the OWCP district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence.

THIS COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR MAIL WITH ALL SUPPORTING DOCUMENTATION BEHIND THIS COVER SHEET.

Signature: **Date:**

DFEC	DEEOIC	DCMWC	DLHWC
U.S. Department of Labor OWCP/ DFEC PO Box 8300 London, KY 40742-8300	U.S. Department of Labor OWCP/ DEEOIC PO Box 8304 London, KY 40742-8304	U.S. Department of Labor OWCP/ DCMWC PO Box 8302 London, KY 40742-8302	U.S. Department of Labor OWCP/ DLHWC PO Box 8313 London, KY 40742-8313

Form: OWCP-FSA