PROVIDER′S PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS′ COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

HEALTH CARE PROVIDER

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____

EMPLOYER

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____

EMPLOYEE

NAME: _____
LAST FOUR DIGITS SSN: XXX-XX- _____
DATE OF INJURY: _____
BOARD FILE NUMBER (if known): _____

INSURER

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____

NOTICE

When there is no ongoing dispute, if bills for medical or health care services are not paid within 30 days after the carrier has received notice of nonpayment by certified mail from the provider of the medical or health care services or, if the bill was paid by the employee, from the employee who paid for the medical or health care services, $50 or the amount of the bill due, whichever is less, must be added and paid to the provider of the medical or health care services or, if the bill was paid by the employee, to the employee who paid for the medical or health care services for each day over 30 days in which the bills for medical or health care services are not paid. Not more than $1,500 in total may be added pursuant to this subsection.

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME) sustained a work-related injury while working for _____ (EMPLOYER NAME).

2. The treatment included _____ (DESCRIBE THE TREATMENT PROVIDED)

   for the employee's injured _____ (LIST BODY PARTS INJURED).

3. The charges related to the medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of the employee's work-related injury or disease are as set forth on the attached bills (do not attach statements).

THEREFORE, the provider asks the board to order benefits pursuant to Title 39 or 39-A.

_____
SIGNATURE OF PETITIONER

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested,** to each other party named in the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

_____
NAME OF PROVIDER'S ATTORNEY (IF ANY)

_____
STREET/P.O. BOX

_____
CITY, STATE, ZIP

_____
TELEPHONE NUMBER

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.