



Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

DWC060, Request for **Medical Fee Dispute** **Resolution Form**

ATTENTION

Health Care Providers

Use this form if:

- Your medical bills were denied by the carrier for fee reimbursement reasons only and not denied for lack of medical necessity.
- The reimbursement for medical bills in dispute does not involve a private contractual arrangement with the carrier for a predetermined fee amount.

ATTENTION

Injured Employees

Use this form if:

- You have tried to get reimbursement from your workers' compensation insurance carrier or doctor for out of pocket medical expenses, including copayments.

NOTE: If your medical bills or requested health care services were denied by the carrier for lack of medical necessity, contact the carrier or its utilization review agent according to rule 133.308.



Texas Department Of Insurance

Division of Workers' Compensation
Medical Fee Dispute Resolution
7551 Metro Center Dr. Ste.100 • MS-48
Austin, TX 78744-1609
(512) 804-4812 (512) 804-4811 fax www.tdi.state.tx.us

DWC Claim#

Carrier Claim#

← Send the completed form to this address

MEDICAL FEE DISPUTE RESOLUTION REQUEST/RESPONSE (FORM DWC060)

PART I: REQUESTOR INFORMATION - Requestor completes this section		
Type of Requestor: <input type="checkbox"/> Injured Employee <input type="checkbox"/> Health Care Provider (Health Care Provider, please note: If the health care services in question were denied for unresolved compensability, extent of injury issues, or liability: <ul style="list-style-type: none"> You are a subclaimant to the dispute by completing the DWC 60 You may dispute the carrier's denial for compensability, liability or extent of injury. Someone from the Division will contact you to give you helpful information about the dispute process. 		
Requestor's Name:	Contact's Name (if other than requestor):	
Requestor's address:	Contact's Phone #:	
City, State, ZIP:	Contact's Fax #:	Contact's e-mail:
PART II: GENERAL CLAIM INFORMATION - Requestor completes this section; Respondent supplements information		
Injured Employee's Name:	Treating Doctor's Name:	
Date of Injury: (mm/dd/yyyy)	Treating Doctor's Telephone #:	
Injured Employee's Telephone #: ()	Treating Doctor's Fax #: ()	
Injured Employee's Social Security # (last 4):	Treating Doctor's E-mail:	
Employer's Business Name:	Insurance Carrier's Name:	
Insurance Carrier's Address:	Insurance Carrier Telephone #: ()	
PART III: RESPONDENT INFORMATION - Respondent completes this section Submit a copy of the RESPONSE, including any information not previously submitted by the REQUESTOR, to the Division and the REQUESTOR.		
Type of Respondent: <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Insurance Carrier		
Respondent's Name:	Contact's Name (if other than respondent):	
Respondent's Address:	Contact's Telephone #:	
City, State, ZIP:	Contact's Fax # :	Contact's e-mail:
I certify, by the attached evidence of resolution, the reported medical dispute has been resolved. Signed _____ Is there an unresolved dispute regarding liability, compensability or extent of injury related to this medical dispute? <input type="checkbox"/> No <input type="checkbox"/> Yes I certify that the carrier had not previously received the requestor's disputed billing or the employee's request for reimbursement in Accordance with Workers' Compensation Rule 133.240 prior to this request for medical dispute resolution. Signed _____		
PART IV: For DWC Use only		
Date Stamp for Receipt from Requestor	MDR Tracking Number	Date Stamp for Receipt from Respondent:

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.



**INSTRUCTIONS FOR COMPLETING THE DWC060
MEDICAL FEE DISPUTE RESOLUTION REQUEST / RESPONSE FORM**

Requestor:

- Complete the DWC060 and include documentation required by Rule 133.305 and 133.307.
- File two (2) copies of the request and all documentation with Medical Fee Dispute Resolution by any mail service or personal delivery. The address for DWC is on page 1 and 2 of the form.
- Complete Parts I, II (as known), and V. If known, the Requestor should provide the Respondent's fax and e-mail address.

Respondent:

- Submit by mail or fax one completed copy of the response to DWC and send one copy to the requestor.
- Complete Part II (if any sections not completed by Requestor), Part III, the last column of Part V, and attach any missing explanation of benefits (EOBs) or denials that establish the fee dispute issues.

The DWC FORM060 and all accompanying documents **MUST** be **legible**. All telephone and facsimile numbers must include the area code.

PART I: The Requestor completes Part I of the DWC060 and provides key information about the requestor. The Requestor should mark any inapplicable fields by filling in "NA". For example, if the Requestor does not have an e-mail address or professional license #, the Requestor should write "NA" in those boxes.

PART II: The Requestor must fill in all available information known in this section. The Respondent must provide any remaining information. Although neither the Requestor nor the Respondent will likely know all of the required information, between the two, all the information should be available. For example, if the Requestor is a health care provider, the carrier claim # or the e-mail address might not be known but this information would be available from the carrier Respondent and should be provided on the DWC FORM060 response. Therefore, no fields should be marked "NA".

PART III: The Respondent completes Part III of the DWC060 with information about the Respondent. After the information section of Part III, the Respondent is asked to consider three different situations that might arise. If any of those situations pertains to the medical dispute, the Respondent will be required to:

- a. certify that the dispute has been resolved and provide evidence of that resolution; or
- b. provide a DWC PLN-1 or 11 if there exists an unresolved dispute for liability, compensability or extent of injury as it relates to the medical dispute; and/or
- c. certify that the Requestor's request for reconsideration was not received by the carrier in accordance with Workers' Compensation Rules 133.240 prior to the request for medical dispute resolution on the disputed billed charges.

The Respondent should also indicate any inapplicable fields by filling in "NA". For example, if the Respondent does not have an e-mail address or professional license #, the respondent should write "NA" in those boxes.

PART IV: Division staff completes Part IV for DWC tracking purposes.

PART V: The Requestor is required to complete the Table of Disputed Services to clearly identify and specify all unresolved health care billing in order to establish a medical fee dispute. The information in this table must include detailed entries for each item. Do not use quotation marks in the table for repeated information. The Respondent is required to provide rationale in the last column of the table. The correlating EOBs are required to establish the dispute issues. If the carrier did not provide EOBs, the Requestor is required to attach to the DWC060 any convincing evidence of the carrier receipt of the request for an EOB.