

# 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: XXXX-XX-\_\_\_\_\_  
DATE OF INJURY: \_\_\_\_\_  
BOARD FILE NUMBER: \_\_\_\_\_

## 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 \_\_\_\_\_, \_\_\_\_\_ sustained a work-related injury while working for \_\_\_\_\_.  
MONTH DAY YEAR EMPLOYEE NAME 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.

WCB-190A (eff. 10/1/15)