
Name of party Submitting

Address of party Submitting

Phone of party Submitting

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

_____ Provider,)	
)	MOTION FOR APPROVAL
)	OF DISPUTED CHARGE
v.)	
)	
_____ Payor.)	PATIENT:
)	DATE(S) OF SERVICE:
_____)	DISPUTED AMOUNT: \$

Comes now _____, Provider, pursuant to Rule 19, JRP, and requests the Industrial Commission of the State of Idaho for an order approving the fees for health care services set forth in Appendix "A" attached hereto, which fees have been disputed. Payor has twenty-one (21) calendar days from the date it receives this request to file its response. Rule 19, JRP.

Documents submitted in support of this motion are attached hereto and include the following:

1. Appendix A (List of Disputed Charges)
- 2.
- 3.
- 4.
- 5.

DATED this _____ day of _____, 20____.

Provider or Agent

Print or Type Name

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20____, a true and correct copy of this Motion was served upon each of the following, as noted:

IDAHO INDUSTRIAL COMMISSION
MEDICAL FEE DISPUTE COORDINATOR
PO BOX 83720
BOISE ID 83720-0041
Fax Number:
Email Address:

US Mail	_____
Hand Delivery	_____
Fax	_____
Email	_____

Payor's Address:

US Mail	_____
Hand Delivery	_____
Fax	_____
Email	_____

Fax Number:

Email Address:

Provider or Agent Signature

Print or Type Name

APPENDIX A
MOTION FOR APPROVAL OF DISPUTED CHARGE

Date of Service	CPT Code / Item Description (CPT Code is preferred)	Amount Billed	Amount Paid	Amount Objected to
TOTALS	(expand as necessary)			