

REQUEST FOR ENFORCEMENT OF ADMINISTRATIVE DECISION

**Attn: Scott Clark, Senior Attorney
Mississippi Workers' Compensation Commission**

Date:

RESPONSE FROM PAYER: (i.e. Partial payment)

Date of MWCC Administrative Decision: _____ MWCC-CC #: _____

Amount of Decision: : _____ (Amount Owed)

Provider:

Patient ID#:

Claimant:

Claim #:

Date(s) of Service:

Payer:

Payer Address:

Service Type: (i.e.: Inpatient - DRG 432)

Total Charges:

Provider Bill Date/Date Received by Payer:

MWCC Fee Schedule Allowable: \$ _____

1st Payment Amount: \$ _____ Payment Date: _____

2nd Payment Amount: \$ _____ Payment Date: _____

Date of Last Written Notification by Provider to Payer:

Date of Last Telephonic Communication by Provider to Payer:

MWCC Fee Schedule Allowable Amount Due: \$ _____

1.5% Interest and 10% Penalty Amount Due, if applicable: \$ _____ thru ___/___/___

TOTAL AMOUNT DUE: \$ _____

CC: (Payer)