**Tennessee Bureau of Workers' Compensation**
**220 French Landing Drive, I-B**
**Nashville, TN 37243-1002**
**800-332-2667**

**FORM C-47**

# MEDICAL PAYMENT COMMITTEE REVIEW REQUEST

| Total Amt Billed | Total Amt Paid | Total Amt Expected | PPO Discount (*if applicable*) | ☐ Amt Due Provider<br>☐ Amt Due Payer |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |

State File #: _____ Date of Injury _____ Requesting Party:_____

Mailing Address: _____ City _____

State & Zip: _____ Email Address: _____

Claimant Name: _____ Date of Service: _____

Employer: _____

Insurer: _____ Adjuster Name _____

Mailing Address: _____ City _____

State & Zip: _____ Email Address: _____

1) Has the bill been sent for reconsideration by Bill Review Company? _____ Yes _____ No
2) If so, name of Bill Review Company? _____

   Mailing Address: _____ City _____

   State & Zip: _____ Email Address: _____
3) What were the findings? _____

_____

**NOTE:** Please provide an un-redacted copy of the documents listed below with this form:

☐ Initial EOR and the Reconsideration EOR ☐ Bills ☐Itemized Bills ☐Pertinent Medical Records

And if applicable: ☐Operative Notes ☐Anesthesia Records ☐Implant Invoices ☐Implant Log

**NOTE:** Please email the documents to suzy.douglas@tn.gov after redacting the following:

☐ Claimant Name ☐ SSN ☐DOB ☐Medical Record # ☐Insurance claim #

_____

Signature of Requesting Party Date of Request Telephone Number