Minnesota Department of Labor and Industry
443 Lafayette Road N., St. Paul, MN 55155 • 651-284-5153

Reset

Penalty Request for Failure to Pay or Deny Rehabilitation Invoice

Submit a separate penalty request form for each instance where services were not timely paid or denied.

Employee: _____ Claim no: _____

WID no: _____ Insurer and TPA: _____

DOI: _____ Adjuster: _____

I request that a penalty be assessed under Minnesota Statutes, section 176.221, subdivision 6a, for the insurer's failure to comply with Minnesota Rules 5220.1900, subpart 1g, by failing to (check one or both):

☐ pay or deny payment of rehabilitation services in writing within 30 days after receipt of the invoice.

☐ identify in writing the specific charges and services for which payment was denied and reasons for the denial.

I have attached a copy of the following documentation (check all that apply)

☐ **Required** 1**:** The invoice submitted to the insurer (including self-insured employer or third-party administrator).

☐ **Required** 2**:** Email, fax confirmation sheet or other correspondence documentation of the date or dates the invoice was submitted to the insurer.

☐ If applicable, the insurer's response to the invoice and the date the insurer's response was received by the rehabilitation provider.

☐ I have not yet received any response to the invoice submitted to the insurer.

☐ If applicable, a copy of the Rehabilitation Request or Rehabilitation Response form filed with the Department of Labor and Industry related to payment of services on the invoice.

☐ If applicable, correspondence from the Department of Labor and Industry about payment for the rehabilitation services on the invoice, such as certification or noncertification of a dispute or a Decision and Order.

☐ If applicable, documentation of communication with the insurer about failure to timely pay or deny payment of the invoice, such as copies of email messages, a phone log of calls or the provider's notice to the parties, letters, a progress report or an R-3 Plan Amendment form under Minn. R. 5220.1801, subp. 9 (O), about a reduction in services.

Comments:

Person making request (print name) **Phone number** **Email address**

Registered rehabilitation provider firm name **Firm registration number**

Before submitting this form, complete the release of information agreement on page two.

Permission to release information regarding penalty request about the employer/insurer

(Check one of the boxes below, sign and date.)

☐ **I authorize** the Department of Labor and Industry to release my name as the complainant to the employer or insurer, or their representative, named above. I also authorize the Department of Labor and Industry to release to the employer or insurer, or their representative, whatever facts the department deems necessary to describe the complaint in the course of the investigation.

☐ **I do not authorize** the Department of Labor and Industry to release my name as the complainant to the employer or insurer, or their representative, named above. I understand this will limit the department's ability to investigate the complaint.

Signature **Date**

Return all pages and any supporting documentation to:

Personal and confidential
Michael Hill, CSO specialist
Department of Labor and Industry
443 Lafayette Road N.
St. Paul, MN 55155