Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution
7551 Metro Center Drive, Suite100 • MS-48
Austin, TX 78744-1645
(512) 804-4812 phone

Complete, if known:

DWC Claim #

Carrier Claim #

Medical Fee Dispute Resolution Request

I. REQUESTER INFORMATION

1. Type of Requester (check the appropriate box)

☐ Injured Employee ☐ Health Care Provider ☐ Pharmacy Processing Agent ☐ Subclaimant

2. If Injured Employee is checked in Box 1, provide the following information:

Is the injured employee a first responder, as defined in Texas Labor Code §504.055, who sustained a serious bodily injury*? ☐ Yes ☐ No If yes, the medical fee dispute resolution process will be expedited.

*bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ

3. Requester's Name (Last, First, Middle)	**4. Requester's Address** (Street or PO Box, City, State, Zip Code)	
5. Requester's Phone Number	**6. Requester's Fax Number**	**7. Requester's E-mail Address**

II. CLAIM INFORMATION

8. Injured Employee's Name	**9. Date of Injury** (mm/dd/yyyy)

III. TABLE OF DISPUTED SERVICES

(Not required if Injured Employee is checked in Section I, Box 1. Injured Employees must provide documentation as listed in the *Frequently Asked Questions* on page 3 of this form.)

10. Provide the requested information in the table below.

Dates of Service in Dispute	Treatment or Service Codes in Dispute	Amount Billed	Amount Paid	Amount in Dispute	Place of Service (Code or Description)
TOTAL					

For TDI-DWC Use Only

III. TABLE OF DISPUTED SERVICES (Continued) (Not required if Injured Employee is checked in Section I, Box 1. Injured Employees must provide documentation as listed in the *Frequently Asked Questions* on page 3 of this form.)

Dates of Service in Dispute	Treatment or Service Codes in Dispute	Amount Billed	Amount Paid	Amount in Dispute	Place of Service (Code or Description)
TOTAL from Page 1					
GRAND TOTAL					

Requester's Name:

DWC Claim Number:

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Frequently Asked Questions
Medical Fee Dispute Resolution Request (DWC Form-060)

What documentation is required when filing the DWC Form-060?
The required documentation of disputed services that must accompany the request for medical fee dispute resolution varies depending on the type of entity requesting medical fee dispute resolution as set forth in 28 Texas Administrative Code (TAC), §133.307. See the chart below for guidance for specific types of requesters. In addition, all requesters except injured employees must complete the *Table of Disputed Services*.

Health Care Provider or Pharmacy Processing Agent

- A paper copy of all medical bills related to the dispute
- A paper copy of all medical bills submitted to the insurance carrier for reconsideration
- A paper copy of each explanation of benefits (EOB) related to the dispute (or convincing evidence that the insurance carrier received the request for EOB)
- A copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute, if applicable
- A copy of all applicable medical records related to the dates of service in dispute
- A position statement of the disputed issues in accordance with 28 TAC §133.307(c)(2)(N)
- If the dispute involves health care for which the TDI-DWC has not established a maximum allowable reimbursement or reimbursement rate, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate in accordance with 28 TAC §134.1 or §134.503, as applicable
- A signed and dated copy of the agreement between the agent and the pharmacy (applies only to pharmacy processing agent)
- Other documentation the requester believes is applicable to the medical fee dispute

Subclaimant

Subclaimants must provide the appropriate information and/or documentation with the request that is consistent with the provisions of 28 TAC §140.6 or §140.8 as follows:

- A request made by a subclaimant under Labor Code §409.009 must comply with 28 TAC §140.6.
- A request made by a subclaimant under Labor Code §409.0091 must comply with 28 TAC §140.8.

Injured Employee

- A description of the service(s) in dispute, including the date(s) of service, the amount you paid for each disputed service, and the amount of the medical fee in dispute
- An explanation of why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount
- Proof of injured employee payment (copies of receipts, health care provider billing statements, or similar documents)
- A copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute (or convincing evidence of the injured employee's attempt to obtain reimbursement or refund)

Where do I file the DWC Form-060?
If you are requesting medical fee dispute resolution and you are not the injured employee, you must mail or personally deliver **two (2) copies** of the completed DWC Form-060 and required documentation to the TDI-DWC at the following address:

Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution Section
7551 Metro Center Drive, Suite 100 • MS-48
Austin, TX 78744-1645

If you are the injured employee, you may file by mail or in person as shown above or you may fax the completed DWC Form-060 and required documentation to TDI-DWC at (512) 804-4811.

Is there a deadline for filing the DWC Form-060?
Generally, the request must be filed no later than one year after the date(s) of the service in dispute. Exceptions to the one-year filing deadline can be found in TDI-DWC rule, 28 TAC §133.307(c)(1). The request is deemed filed when it is received in the Medical Fee Dispute Resolution Section at the TDI-DWC.

Questions?
You can get more information about the medical fee dispute resolution process by calling the TDI-DWC Medical Fee Dispute Resolution Section at (512) 804-4812 or e-mailing mdrinquiry@tdi.texas.gov. You can also access the medical fee dispute resolution rules on the TDI website at http://www.tdi.texas.gov/wc/mfdr/.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).