MSCRFB03

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO

PROVIDER **FEE BILL**

Claim Number(s): Claim Type:

Injured Worker's Name:

Provider Number:

Tax ID Number:

Date of Service:

Type of Service	Charges
( ) Exam by Ohio Provider	________
( ) Exam by Out of State Provider	________
( ) File Review by Ohio Provider	________
( ) File Review by Out of State Provider	________
( ) Vocational File Review	________
( ) Interpretive Services	________
( ) Injured Worker "No Show" for Exam	________
( ) Cancellation of Exam (IC Approved)	________
( ) Diagnostic Test Name/CPT Code(s) Required	
________________	________
________________	________
________________	________
Total:	________

I hereby certify that the information contained on this form is true and correct to the best of my knowledge and belief.

____

Provider Signature Date

For I.C. Use Only I.C. Verification:

______________________ ______________________

Initial here for SURPLUS payment (Initials and Date)

ICFEEBILL