Liberty Mutual - Workers Compensation

RECONSIDERATION REQUEST FORM – Please attach Liberty’s EOB

Patient’s Name: ____________________________________________________________

Liberty’s Workers Comp Claim Number: _______________________________________

Provider’s Name: __________________________________________________________

Provider’s Address: ________________________________________________________

Description of Item or Service in Question: ___________________________________

Date of Service in Question or Date of Item in Question: __________________________

I do not agree with the determination of my claim. MY REASONS ARE:

Additional Information Liberty Should Consider:

Requester’s Signature: ___________________________ Date Signed: ________________

☐ I have evidence to submit. (Attach such evidence to this form.)

☐ I do not have evidence to submit.