|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Instructions:** Please complete all applicable fields. Send the completed form to ra-benwc@pa.gov, cfitzpatrick@homsinc.net, sulp@pnat.com and insvacct400@pnat.com. You may add information to the subject line, and you may include an email introduction, but it is not required since all of the information should be contained on this form. | | | | | | | |
| **Requestor:** | | | | | | | |
| Name | | Telephone | | | Email | | Today’s Date |
|  | |  | | |  | |  |
| Agency/Field Site Location | | | | | | | |
|  | | | | | | | |
| **County Panel:** | | | | | | | |
| **Type of Request:** Request to Add Request to Remove General Complaint | | | | | | | |
| Provider | | | Provider Number | | Provider Specialty | | |
|  | | |  | |  | | |
| Applicable County Panel(s) | Provider Address | | | | | | |
|  |  | | | | | | |
| **Please complete for complaints:**  Quality of care  Provider attitude/bedside manner  Unable to see injured employee timely  Not providing medical information timely  Charging for completion of forms  Other | | | | **Please complete for removals:**  Retired/No longer practicing  Physician no longer with the practice  No longer accepting workers’ compensation patients  No longer at this address  Other | | | |
| **Reasons for Request or Additional Information:** | | | | | | | |
|  | | | | | | | |
| **Claimant Name, Claim Number, Date of Injury; if applicable:** | | | | | | | |
|  | | | | | | | |
| **For Inservco Use Only:** | | | | | | | |
| Comments | | | | | | | |
|  | | | | | | | |
| Reviewer | | | | | | Date | |
|  | | | | | |  | |