

  
**WORKERS' COMPENSATION COMMISSION**  

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**CONTROVERSION OF MEDICAL CLAIM**

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**INSTRUCTIONS:** This form is to be used **ONLY** for the purpose of controverting an Order Nisi and **MAY NOT** be used to raise any other issue. If other issues exist WCC Form H24R "Issues" must be filed with the Commission. Pursuant to COMAR 14.09.08.06G a hearing will be scheduled on this controversion in the normal course.

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**WCC Claim Number:**

**Claimant Name:**

**Employer:**

**Insurer:**

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**The            Employer/Insurer            Healthcare Provider    hereby controverts  
the Order Nisi issued in this case for professional services provided by:**

**Healthcare Provider**

**Street**

**Suite/Additional Address**

**City**

**State**

**ZIP Code**

**A Final Order should not be issued for the following reason(s):**

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**CERTIFICATION OF SERVICE**

I hereby certify that on this            day of            ,            , I mailed, postage prepaid,  
a copy of the foregoing "Controversion of Medical Claim" to all parties and their attorneys.

Name of Party Raising Issues

Signature

Telephone Number

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**10 East Baltimore Street · Baltimore, Maryland 21202-1641  
410-864-5100 · Email: [info@wcc.state.md.us](mailto:info@wcc.state.md.us) · Web: <http://www.wcc.state.md.us>**