State of Ohio
WILMAPC
Workplace Injury Labor Management Approved Provider Committee

For WILMAPC Use Only Date

Received_____Review Date

_____

Provider Notice of Appeal

Provider Name:	Provider Address:	
Practice Name:	Provider Type:	Provider Specialty (if applicable):
Provider E-mail Address :	Phone #:	Fax #:
Contact Name (if other than provider):	Phone # for Contact Person:	Fax # for Contact Person:

I am appealing removal from the WILMAPC Provider Panel.

The basis of appeal is as follows (attach supporting documentation, if applicable):

☐ *Check here if additional information is attached.*

By signing below, I affirm that the information submitted herein is true and accurate to the best of my knowledge and that I have not included any information which I am not legally permitted to share with WILMAPC. I further agree to indemnify and hold WILMAPC harmless from and against any and all losses, expenses and/or damages sustained as a result of, or arising out of, my providing legally protected information with my appeal. I also acknowledge that I have read and understood the relevant deadlines contained in the "Instructions to Providers For Filing an Appeal." **WILMAPC's decision regarding this appeal is final.**

Signature **Date**

This form and any attachments may be e-mailed to das.ocbinfo@das.ohio.gov, faxed to (614) 644-0121, or mailed to 4200 Surface Road, Columbus, OH 43228. Electronic submission is preferred.