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| COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  Division of Workers’ Compensation  633 17th Street, 4th Floor | Denver, CO 80202-3626  Phone: (303) 318-8700 | Fax: (303) 318-8758  [cdle\_medicalpolicy@state.co.us](mailto:cdle_medicalpolicy@state.co.us) | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL DISPUTE RESOLUTION INTAKE FORM** | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |  | |
|  | Name of Contacting Party: | | | | | | |  | | | | | | | | | | | |  | |
|  | Title: | | | | | | |  | | | | | | | | | | | |  | |
|  | Mailing Address: | | | | | | |  | | | | | | | | | | | |  | |
|  | Email Address: | | | | | | |  | | | | | | | | | | | |  | |
|  | Phone: | | | | |  | | ( ) | | Fax: | | | | | | | ( ) | | |  | |
|  |  | | | | | | | | |  | | | | | | | | | |  | |
|  | Provider/Payer Initiating Dispute: | | | | | | |  | | | | | | | | | | | |  | |
|  | NPI or Tax ID#: | | | | | | |  | | | | | | | | | | | |  | |
|  | Other Party Involved in Dispute: | | | | | | |  | | | | | | | | | | | |  | |
|  |  | | | | |  | | | |  | | | | | | |  | | |  | |
|  | Claimant: | | |  | | | | | | Date(s) of Service: | | | | | |  | | | |  | |
|  | Employer: | | |  | | | | | | Date(s) of Injury: | | | | | |  | | | |  | |
|  |  | | | | | | | | |  | | | | | | | | | |  | |
|  | Disputed amount: | | | | | | | | |  | | | | | | | | | |  | |
|  | * Payment you received: | | | | | | | | | | $ | |  | | | | | | |  | |
|  | * Payment you believe you should have received: | | | | | | | | | | $ | |  | | | | | | |  | |
|  | * Explain how you arrived at this amount: | | | | | | | |  | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | |  | | | |  | | |  |  |  | |
|  | Have you followed the procedures in Rule 16-12(D)? | | | | | | | | | | □ | | | | Yes | | | □ | No |  | |
|  | If not, why? | | | |  | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | |  | |
|  | Issue(s) in Dispute (check all that apply): | | | | | | | | | | | | | | | | | | |  | |
|  | □ | Rule | | | | |  | | | □ | | UCR | | | | | | | | |  |
|  | □ | CPT® | | | | | | | | □ | | Supply | | | | | | | | |  |
|  | □ | PPO Contract | | | | | | | | □ | | Other | |  | | | | | | |  |
|  | Briefly explain the dispute: | | | | | | | | | |  | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | |  | |
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|  |  | | | | | | | | | | | | | | | | | | |  | |
|  | What actions have you taken to resolve this dispute? *(Include person(s) you spoke with and date(s) if available)* | | | | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | |  | |
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|  |  | | | | | | | | | | | | | | | | | | |  | |
|  | Please attach all applicable supporting documents: | | | | | | | | | | | | | | | | | | |  | |
|  |  | |  | | | | | | |  | |  | | | | | | | | |  |
|  | □ | | Original bill | | | | | | | □ | | Office/procedure/operation notes | | | | | | | | |  |
|  | □ | | EOB(s)/EOR(s) | | | | | | | □ | | Call logs/emails | | | | | | | | |  |
|  | □ | | Prior authorization | | | | | | | □ | | Correspondence from other party | | | | | | | | |  |
|  | □ | | Invoice(s) | | | | | | | □ | | Copy of request for contract | | | | | | | | |  |
|  | □ | | Appeal(s) | | | | | | |  | |  | | | | | | | | |  |
|  | | | | | | | | | |  | |  | | | | | | | | |  |
| WC 181 Rev. 03/18 | | | | | | | | | |  | |  | | | | | | | | |  |