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| COLORADO DEPARTMENT OF LABOR AND EMPLOYMENTDivision of Workers’ Compensation633 17th Street, 4th Floor | Denver, CO 80202-3626Phone: (303) 318-8700 | Fax: (303) 318-8758cdle\_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: |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | What actions have you taken to resolve this dispute? *(Include person(s) you spoke with and date(s) if available)* |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | 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 |  |  |  |