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

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 ______________
☐ CPT®
☐ PPO Contract
☐ UCR
☐ Supply
☐ 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
☐ EOB(s)/EOR(s)
☐ Prior authorization
☐ Invoice(s)
☐ Appeal(s)
☐ Office/procedure/operation notes
☐ Call logs/emails
☐ Correspondence from other party
☐ Copy of request for contract