



CERTIFIED WORKPLACE MEDICAL PLAN DISPUTE RESOLUTION FORM

Before you complete this form, have you contacted your plan by phone or fax, and discussed your complaint with a Certified Workplace Medical Plan representative? Some issues may be addressed without the need for formal Dispute Resolution.

This form is to be used by any Employee, Employer, Network Provider, Participating Physician or Insurance Carrier associated with the (Plan's name) Certified Workplace Medical Plan, who has a complaint that relates to medical care under the plan including a request for change of physician with the CWMP Network. Complete all the requested information such as dates, names, and the specific resolution which you feel would remedy the situation. All available medical records will be reviewed. You will receive an answer within ten (10) days of the date the dispute is received, unless necessary information is not available in the normal course of business.

Person filing the dispute: Circle one of these choices:

- (a) Employee (b) Employer (c) Network Provider (d) Participating Physician (e) Insurance Carrier

EMPLOYEE INFORMATION: Please Print or Type:

Last Name : _____ First Name : _____ Middle Initial: _____ Daytime Phone Number: (_____) _____

SSN#: _____ Date of Injury : _____ Body Part: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PROVIDER INFORMATION:

Name : _____ Phone Number: (_____) _____

Address : _____ City : _____ State : _____ Zip Code _____

EMPLOYER INFORMATION:

Name: _____ Phone Number: (_____) _____

Address : _____ City: _____ State: _____ Zip Code: _____

INSURANCE CARRIER INFORMATION:

Name of Carrier: _____ Phone number: (area code) _____

Address: _____ City : _____ State: _____ Zip Code: _____

- Briefly describe the situation that prompted this dispute. Provide dates, names, and any other pertinent facts that relate to the dispute. State what actions CompCHOICE could take to remedy your dispute:

Signature

Date