WCD Workers' Compensation Division
Department of Consumer and Business Services

Request for Dispute Resolution of Medical Issues and Medical Fees

Complete this form to request medical dispute resolution services from the Workers' Compensation Division. You must notify all parties to the dispute about this request and provide the parties copies of any information submitted to the director. Copies must be provided free of charge to all other concerned parties. **Unrepresented workers may call the Medical Resolution Team for help in completing the form.** As an alternative to the administrative review process, a less formal dispute resolution process may resolve your issue. This process allows you to work with a trained facilitator on the Medical Resolution Team. The parties work with a facilitator collaboratively to reach agreement. A medical reviewer may contact you about this process, or you may contact the Medical Resolution Team at 503-947-7606.

Dispute information

What is the specific medical issue in dispute? _____

Dates of services in dispute: _____

Why is the medical issue in dispute? _____

Accepted conditions (medical conditions the insurer accepted in writing or by litigation):

_____

Dates of written acceptance, including Updated Notice of Acceptance: _____

(Note: For medical fee disputes, complete both Form 2842 and Form 2842a)

Worker information

Worker name: _____ Phone: _____

Address: _____ City, State, ZIP: _____

Date of injury: _____ Claim no.: _____

Employer/insurer information

Employer name: _____

Employer's workers' compensation insurer: _____

Insurer address: _____

Insurer phone: _____

Provider information

Medical provider name: _____ Phone: _____

Address: _____ City, State, ZIP: _____

Contact person: _____

Are you the attending physician (AP)? ☐ Yes ☐ No

If no, indicate name of AP: _____ Phone: _____

Address: _____ City, State, ZIP: _____

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Managed care organization (MCO) information

☐ Yes ☐ No Is the worker covered by an MCO contract?

If yes, MCO name: _____ Enrollment date: _____

☐ Yes ☐ No Does MCO have a dispute resolution process?

If yes, date on which process was initiated: Date completed:

If yes, all documents generated for the MCO review must be submitted with this form.

Review requested by

☐ Worker
☐ Insurer
☐ Medical service provider
☐ Other: _____
☐ Worker's attorney
☐ Insurer's attorney
☐ Managed care organization

- ❖ Attach copies of all relevant medical information or records to this form.
- ❖ Provide a copy of the completed request and supporting documentation to all parties.

Failure to comply with these requirements may result in dismissal of your request.

Insurer's certification statement (required only if the insurer requests review)

By signing below, I certify that relevant medical and claim information has been provided with this request and that copies have been sent to all parties as required by OAR 436-010-0008.

Insurer's signature: _____ Date: _____

Send the completed, signed original of this form and all accompanying documents to:

Workers' Compensation Division
Medical Resolution Team
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Or fax it to: 503-947-7629

For help or more information, please call the Medical Resolution Team, 503-947-7606.