



Workers' Compensation Division

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 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 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 Resolution Team at 503-934-6049.

Directions

Indicate below what issue(s) you are submitting for review:

- Medical services (palliative care, medical services after medically stationary, out-of-pocket expenses, unpaid bills, etc.) ORS 656.245
- Managed care organization (MCO) dispute ORS 656.260
- Change of attending physician or nurse practitioner ORS 656.245
- Medical rules violation (requests re: elective surgery, treatment plans, etc.) ORS 656.327
- Appropriateness of medical treatment ORS 656.327
- Medical fee dispute (reduced payment) ORS 656.248
(Note: For medical fee disputes, complete both Form 2842 and Form 2842a)

Attention providers: For more than three disputes of the same type, call the Resolution Team at 503-934-6049 regarding an expedited process with less paperwork.

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 Are you the nurse practitioner (NP)? Yes No
 If no, indicate name of AP or NP: _____ Phone: _____
 Address: _____ City, State, ZIP: _____

(continued on back)

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.

Dispute information

What is the specific medical issue in dispute? _____

Date(s) of services in dispute: _____

Why is the medical issue in dispute? _____

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

Date(s) of written acceptance, including Updated Notice of Acceptance: _____

Review requested by

Worker

Worker's attorney

Insurer

Insurer's attorney

Medical service provider

Managed care organization

Other: _____

Please attach to this form copies of all relevant medical information or records.
Failure to comply with these requirements may result in dismissal of your request.

Insurer: Please complete the following certification statement.

Insurer's certification statement

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, pursuant to 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 Section
Resolution Team
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

For help or more information, please call the Resolution Team, 503-934-6049.