



Instructions

- Please print or type.
Complete this form to the best of your knowledge.
This form may also be used to withdraw this appeal by completing the withdraw appeal section in the instructions.
The injured worker, employer, authorized representatives or provider must file this appeal with the injured worker's managed care organization (MCO).
Use this form to appeal the MCO's medical treatment/service decision and to start the alternative dispute resolution (ADR) process.
You must file your appeal with the MCO within 14 days of receipt of the written notice of the MCO's initial medical treatment/service decision.

The injured worker name and BWC claim number are mandatory.

Table with 2 columns: Injured worker name, BWC claim number

Appealed by: (check appropriate box)

Table with 3 columns: Name, ID number, Telephone number. Rows include Injured worker name, Injured worker representative name, Employer name, Employer representative name, and Provider name.

Date of MCO initial decision letter:

Date of receipt of MCO initial decision:

Was this treatment/service decision [] Denied [] Approved [] Amended
Specify medical treatment/service you wish to appeal.

Enter start date of requested treatment: Enter total number of treatments: [] per week for weeks OR [] per month for months

Give reason for the appeal. Please be specific, include any relevant information, any new evidence that will assist in approval of your appeal. (Attach additional documentation if necessary.)

Signature of party filing appeal Date

Withdraw appeal

I withdraw the above referenced appeal
(Signature of party withdrawing appeal) (Date)