



Instructions

- The injured worker, employer, authorized representatives or provider must file this appeal with the injured worker's MCO.
Please print or type.
Use this form to appeal the managed care organization (MCO) medical treatment/service decision and to start the alternative dispute resolution (ADR) process.
You must file appeal to Level 1 within 14 days of receipt of the written notice of the MCO initial medical treatment/service decision.
You must file appeal to Level 2 with the MCO within seven days of the receipt of written notice of the MCO Level 1 decision.
Complete this form to the best of your knowledge.

The injured worker name and BWC claim number are mandatory.
Injured worker name | BWC claim number

Appealed by: (check appropriate box)

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

- Level 1 Appeal to MCO - Check if this is to appeal the initial MCO treatment/service decision. Date of MCO initial decision letter: Date of receipt of MCO initial decision:
Level 2 Appeal to BWC - Check if this is to appeal the MCO Level 1 decision and refer the dispute to BWC. Date of MCO Level 1 decision: Date of receipt of written notice:

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