

Department of Labor and Industry
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221
 (651) 284-5032 or 1-800-342-5354
 Fax: (651) 284-5731

Attorney Request for Certification of Dispute

PRINT IN INK or TYPE
 ENTER DATES in MM/DD/YYYY FORMAT



CA0022
 DO NOT USE THIS SPACE

Notice to employee: Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by Department of Labor and Industry staff members who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the Office of Administrative Hearings; the Workers' Compensation Court of Appeals; the Departments of Revenue and Health; and the Workers' Compensation Reinsurance Association.

Employee name		Phone # (include area code)		WID number or SSN		Date of injury	
Employee address				Insurer/self-insurer/TPA			
City		State	ZIP code	Insurer address			
Employer name				City		State	ZIP code
Employer address				Claim representative name			Insurer fax #
City		State	ZIP code	Insurer claim #		Insurer phone #	Ext.

If medical services are disputed, are they being provided or managed by a certified managed care plan? Yes No

If yes, attach information showing that the managed care plan dispute procedure has been exhausted (per 176.1351, subd. 3).

Nature of the rehabilitation or medical dispute. **If there are unpaid medical bills, itemize below and attach.**

Health care provider name	Service date(s)	Dollar amount	Date bill submitted to insurer
	-		
	-		
	-		
	-		

Reason given by insurer for denial (if known). **Attach insurer bill review or other response.**

Attorney name (print or type)		Attorney signature		Phone #		Ext.	
Address				Fax #			
City		State	ZIP code	Date submitted			