CORVEL

10900 Hefner Pointe Drive
Suite 410
Oklahoma City, OK 73120

(405)254.2441 phone
(800)496.3385 toll free
(866)915.1115 fax

CERTIFIED WORKPLACE MEDICAL PLAN
DISPUTE RESOLUTION PROCESS

The Dispute Resolution Process is available to any injured worker, employer, participating provider, or insurance carrier who may have an issue *relating to medical care*. The Dispute Resolution Procedure must be pursued and completed in accordance with TITLE 85 of the Oklahoma Statutes, Section 14.3. An individual must exhaust the Dispute Resolution Process prior to seeking remedy in the Oklahoma Workers' Compensation Court.

When a Certified Workplace Medical Plan's office receives notice of a dispute, a resolution will be offered within ten (10) days. The ten-day time frame may be extended if necessary to gather further medical information relating to the dispute. If an extension is necessary, a written notice will be sent to all parties.

The Dispute Resolution Process consists of four (4) steps:

- ✓ **STEP 1:** A dispute resolution form is to be completed and received at the Certified Workplace Medical Plan's Office. Should the dispute be a denial of service, the injured worker, employer, participating provider, or insurance carrier, has forty-eight hours to inform CorVel of notice to appeal the decision.
- ✓ **STEP 2:** Upon receipt of a completed Dispute Form the Certified Workplace Medical Plan will attempt to resolve the dispute. If the issue can be resolved by CorVel, a final report will be sent to all applicable parties.
- ✓ **STEP 3:** If the Certified Workplace Medical Plan is unable to resolve the dispute, it will be referred to the Medical Director for settlement. If resolution is achieved, a final report will be submitted to all applicable parties.
- ✓ **STEP 4:** If the Medical Director feels additional expertise is required to resolve the matter, the dispute form and all available medical information pertaining to the issue, will be sent to either a specialist or a panel of health care providers per the Medical Director's discretion.

CERTIFIED WORKPLACE MEDICAL PLAN DISPUTE RESOLUTION FORM

Before you complete this form, have you contacted your plan by phone or fax, and discussed your complaint with a Certified Workplace Medical Plan representative? Some issues may be addressed without the need for formal Dispute Resolution.

This form is to be used by any Employee, Employer, Network Provider, Participating Physician or Insurance Carrier associated with CorVel's Certified Workplace Medical Plan, who has a complaint that *relates to medical care under the plan.* Complete all the requested information such as dates, names, and the specific resolution which you feel would remedy the situation. All available medical records will be reviewed. You will receive an answer within ten (10) days of the date the dispute is received, unless necessary information is not available in the normal course of business.

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Person filing the dispute: Circle one of these choices:

(a) Employee (b) Employer (c) Network Provider (d) Participating Physician (e) Insurance Carrier

EMPLOYEE INFORMATION: Please Print or Type:

Last Name: First Name: Middle Initial: Daytime Phone No: (area code)

SSN#: Date of Injury: Body Part:

Address: City: State: Zip Code:

PROVIDER INFORMATION:

Name : Phone Number: (area code)

Address: City: State: Zip Code:

EMPLOYER INFORMATION:

Name: Phone Number: (area code)

Address: City: State: Zip Code:

INSURANCE CARRIER INFORMATION:

Name of Carrier: Phone number: (area code)

Address: City: State: Zip Code:

- Briefly describe the situation that prompted this dispute. Provide dates, names, and any other pertinent facts that relate to the dispute. State what actions CorVel could take to remedy your dispute:

_____ _____

Signature **Date**

_____ _____

PRINT NAME CLEARLY **PHONE / FAX NUMBERS**