Medical Request

Reset

CHECK BOX IF THIS REQUEST ADDS MEDICAL ISSUES TO A PENDING MEDICAL REQUEST ☐

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

NOTE: File this form with the Department of Labor and Industry at the address or fax number at the end of this form. Before filing this form, call the workers' compensation insurer or the Workers' Compensation Alternative Dispute Resolution Unit at 651-284-5032 or 1-800-342-5354.

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS			INSURER/SELF-INSURER/TPA		
CITY	STATE	ZIP Code	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP Code
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP Code	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- This form must be filled out **completely**; otherwise, it may be **returned** to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, vocational rehabilitation, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Alternative Dispute Resolution Unit at 651-284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS REQUEST IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ Health Care Provider

2. **Are medical services being provided or managed by a certified managed care plan?** ☐ **YES** ☐ **NO** If yes, attach information showing that the dispute resolution process of the certified managed care plan has already been exhausted.

3. **MEDICAL ISSUES (check only those that apply)**
I request:

☐ a. that health care provider bills be paid. (List all health care providers whose bills or services are in dispute. Attach extra sheets if needed. Itemized bills and supporting medical reports must be attached.)

NAME	ADDRESS	UNPAID BALANCE

☐ b. a change of treating doctor:

FROM:	NAME	ADDRESS	SPECIALTY
TO:	NAME	ADDRESS	SPECIALTY

☐ c. that prescribed treatment, surgery or equipment be provided. (Specify the requested surgery or equipment & attach supporting medical reports.) _____

☐ d. that the employee's medical expenses be reimbursed (e.g., mileage, prescription drugs). Attach supporting medical reports.

☐ e. a second opinion or consultation with

NAME	SPECIALTY

☐ f. other (explain):

IF YOU DO NOT COMPLETE SECTION 4 ENTIRELY, WE WILL NOT BE ABLE TO PROCESS YOUR REQUEST.

4. HAS ANYONE OTHER THAN THE WORKERS' COMPENSATION INSURER PAID HEALTH CARE PROVIDER BILLS RELATED TO THIS DISPUTE? ☐ YES ☐ NO

If yes, bills were paid by: ☐ employee ☐ Veterans Administration ☐ Dept. of Human Services (Welfare)
☐ Medicare ☐ Social Security Administration ☐ private health insurance ☐ other

In the space below, provide the name(s) of the person(s) or organization(s) checked above. Attach extra sheets if necessary.

NAME	ADDRESS	POLICY NUMBER

5. Explain the details of your request. Attach all documents, such as medical reports and bills, and also identify any applicable treatment parameter or other rule that support(s) your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

6. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, health care provider, attorneys, and any party named in #4 above who has paid medical expenses. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #6 on _____ (date)

PRINT NAME OF PERSON FILING THIS REQUEST			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, RETURN IT AND ALL ATTACHMENTS TO:	**In person:** MN Department of Labor and Industry Workers' Compensation Division 443 Lafayette Road N. St. Paul, MN 55155	**Mailing address:** MN Department of Labor and Industry Workers' Compensation Division 443 Lafayette Road N. St. Paul, MN 55155

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 (department) staff 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.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

DEPARTMENT OF LABOR AND INDUSTRY

Instructions for completing a Medical Request form

Submit a Medical Request form if you want to resolve a dispute about a workers' compensation medical issue. You must file the Medical Request form with the Department of Labor and Industry (department) at the address or fax number at the end of the form. Do not file the Medical Request with the Office of Administrative Hearings (OAH) – the department will send the Medical Request to OAH when OAH has jurisdiction under the workers' compensation law. The department may also send the dispute to OAH when authorized by law.

Do not use a Medical Request form if you also have a dispute about rehabilitation, wage loss or permanent partial disability or if the insurer has denied primary liability for the entire workers' compensation claim (denial of primary liability). In these cases you must use an Employee's Claim Petition form.

Item 3 on the front of the Medical Request form lists the most common medical issues in dispute. Here are some guidelines to help you put your dispute in a category.

a. **I request that the insurer pay medical or chiropractic bills.** An injured worker may request the insurer pay medical or chiropractic bills if the insurer has accepted liability for the claim, but is denying payment for any reason. A health care provider may file a request on this issue if there is a dispute about the reasonableness and necessity of their services or about the amount billed. A health care provider should not submit this form if the issue is whether the work injury was responsible for the workers' need for treatment. Do not submit this form unless the insurer has had 30 days to review the bills or has already refused to pay.

b. **I request a change of treating doctor.** The injured worker or the employer/insurer may request a change of doctor. Make sure to fill in the name of the current treating doctor and the name of the doctor whom you want as the primary health care provider. If the employee and insurer agree on a change of doctor, you do not need to file this form.

c. **I request that prescribed treatment, surgery or equipment be provided.** Check this issue if your doctor has prescribed treatment, surgery or equipment but the insurer has not agreed to pay for it. Enclose a copy of a doctor's report stating why you need the treatment, surgery or equipment. If a prescription expense is disputed, include a copy of the prescription. Examples: approval of rotator cuff surgery as recommended by Dr. Jones; three weeks of physical therapy twice a week as prescribed by Dr. Smith; purchase of an exercise bicycle as recommended by Dr. Anderson.

d. **I request that the insurer reimburse my medical expenses.** An injured worker may request expenses incurred in receiving medical care be reimbursed. This includes parking and mileage for medical appointments and any medication for which the injured worker paid. You should check this issue if you have submitted these expenses to your insurer and the insurer has not paid for them. Allow the insurer 30 days to consider the expenses before submitting a request.

e. **I request a second opinion or consultation with_____**. An injured worker may request to see another doctor or other health care provider for another opinion or for a consultation. This can either be as a referral from the primary health care provider or a request the injured worker makes on his or her own. This is usually done when the treating doctor recommends surgery and you are not sure you want to have the surgery and would like another opinion; you may also ask for a second medical opinion/consultation for other medical issues as well.

f. **Other.** Check this item if you have a medical dispute that does not fit under the other categories. Briefly explain what you want.

Item 4. If the department orders the insurer to pay for disputed bills or other costs requested on this form, the insurer also has to reimburse any party who has paid some or all of these costs. The most common example of this is when an injured employee's private health insurance pays for treatment that should have been paid for by the workers' compensation insurer. Therefore, it is important that you complete question 4 so the department knows if there is anyone besides you whom the workers' compensation insurer should reimburse.

Item 5. In item 5, you need to explain the basis for your request. At times, the department may issue a legally binding written decision based on the information you submit on a Medical Request form and from the opposing party's information on the Medical Response form. So it is important that you make your request as complete as possible.

You must attach documents that support your medical request. If you do not provide documentation that supports your request, the department may notify you that your Medical Request form is incomplete and that no further action will be taken on the request until supporting documentation is submitted.

1. If you are requesting payment of medical or chiropractic bills under item 3(a) or reimbursement of medical expenses such as prescriptions or mileage under item 3 (d), you will need to submit copies of the itemized bills, prescriptions or mileage expenses. You will need to submit medical reports, doctor's office notes or other information that supports your position. The standard for compensability is whether the treatment was reasonable and necessary for the cure and relief of the work injury. There are "treatment parameter" rules (in Minnesota Rules, parts 5221.6010 to 5221.6600) that describe what diagnostic procedures, treatments and surgeries are considered reasonable and necessary to cure or relieve certain workers' compensation injuries. The treatment parameters also include exceptions to the parameters, which are called "departures." If you are aware of a treatment parameter or departure that supports your treatment claim, you may list it on the Medical Request form. If you have any questions about the treatment parameters you may call the Alternative Dispute Resolution unit at the number below. Information about treatment parameters is on the Department of Labor and Industry website at www.dli.mn.gov/WC/MedBen5.asp.

2. If you are requesting approval of prescribed treatment, surgery or equipment under item 3(c), you will need to submit a report from a health care provider recommending the treatment. The standard for compensability is whether the treatment is reasonable and necessary for the cure and relief of the work injury. As noted above, you may include on the Medical Request form any treatment parameter that supports your request for treatment, surgery or equipment.

3. If you are requesting reimbursement of medical expenses under item 3(d) such as prescriptions or mileage expenses, you must submit supporting documentation. An example of supporting documentation for a prescription is a copy of the prescription; an example of supporting documentation for reimbursement of mileage or travel to obtain medical treatment of your injury is documentation of the mileage or receipts for other expenses. In addition, if the employer or insurer has denied the expense was necessary for treatment of your work injury, submit documentation that the expense was necessary, such as the examples described in number one above.

4. If you are requesting a change of doctor, a consultation with another doctor or a second opinion with another doctor, explain your reasons. A rule governing change of doctor can be viewed on the Office of the Revisor of Statutes website at www.revisor.mn.gov/rules/?id=5221.0430.

5. In addition to the disputes described above, there can be a separate dispute about whether the need for treatment is due to the work injury. An example of supporting documentation for this could be a report or office notes from a doctor addressing this issue. The standard for compensability is whether the work injury is a substantial contributing factor to a need for medical treatment.

If you have questions about what information to include, call the Alternative Dispute Resolution unit at (651) 284-5032 or 1-800-342-5354.

Item 6. Send a complete copy of all documents to everyone involved in the dispute and list their names and addresses under item 6 on the back of the request form. If you have a question about who should be considered involved, call the Alternative Dispute Resolution unit.

In addition to resolving your dispute through this process, the department can also provide you with trained mediators who may be able to help you resolve your dispute. The department requires that the parties involved in the dispute agree to a mediation. If you are interested in this less formal process, call the Alternative Dispute Resolution unit for more information.