Bureau of Workers' Compensation

ADR Appeal to the MCO Medical Treatment/Service Decision

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.

Injured worker name	BWC claim number

Appealed by: (check appropriate box)

☐ Injured worker name		Telephone number
☐ Injured worker representative name	Representative ID number	Telephone number
☐ Employer name	Contact person	Telephone number
☐ Employer representative name	Representative ID number	Telephone number
☐ Provider name	Specialty	Telephone number

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)