



The BWC disability management coordinator and/or the managed care organization (MCO) use(s) this form when there is a difference of opinion with the vocational rehabilitation case manager's justification for closure.

Injured worker name (Last)		(First)	(M.I.)
Claim number		Date of VR case closure	

MCO justification for closure:

BWC disability management coordinator justification:

MCO representative signature	Date	Phone number
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BWC disability management coordinator signature	Date	Phone number
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