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	