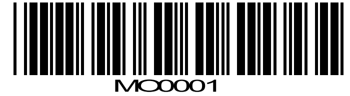
Mailing Address:
PO Box 64221
St. Paul, MN 55164-0218

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
WORKERS' COMPENSATION DIVISION
(651) 361-7900



DO NOT USE THIS SPACE

WID or SSN
DATE(S) OF CLAIMED INJURY

EMPLOYEE VS.
EMPLOYER(S) AND
INSURER (S) AND

Motion/Application to Intervene

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

Re: ______________________________ **dated** ______________
(Identify dispute you are intervening in, such as a Claim Petition, Medical Request, or Rehabilitation Request)

TO THE WORKERS' COMPENSATION DIVISION AND THE ABOVE-NAMED PARTIES:

Applicant, ____, for its Motion to Intervene in the above-entitled matter, states and alleges as follows:

1. That applicant has provided services or paid benefits to the employee as follows: ______________________________
____

2. That attached to this Motion as Exhibit A is an itemization of all charges for services provided or benefits paid by the applicant regarding the workers' compensation injury or injuries. The total claim is $______________ for services provided or payment made from ____________________ *(date)* to ____________________ *(date)*.

3. That a determination in this case may affect the ability of the applicant to obtain payment from any source for services provided or benefits paid as itemized in Exhibit A.

4. In support of this Motion, attached as Exhibit B are (if applicable): ☐ medical records/reports; or ☐ rehabilitation records/reports.

5. That applicant has a statutory right to intervene under Minn. Stat. § 176.361.

6. That in the event settlement is discussed by the parties, applicant requests that ______________________*(name and title)* be contacted at ____________________ *(phone)* regarding authority to settle on behalf of applicant.

Therefore, applicant requests that it be allowed to intervene as a party in the above-captioned proceeding, and that payment for its services provided or benefits paid be made plus appropriate statutory interest.

DATE SIGNED	SIGNATURE OF PERSON FILING MOTION			
	PRINTED NAME AND TITLE			
	ADDRESS			
	CITY	STATE	ZIP CODE	TELEPHONE

WID or SSN
DATE(S) OF CLAIMED INJURY

STATE OF MINNESOTA }
} ss.
COUNTY OF ______________________ }

AFFIDAVIT OF SERVICE

I, ______________________________________ , being first duly sworn, state that on ___________________________________ , I served a true and correct copy of the attached **MOTION/APPLICATION TO INTERVENE**, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid in the United States mail at ________________________ , Minnesota, addressed as follows:

Employee:	Employee Attorney:
Employer:	Employer/Insurer Attorney:
Insurer:	Other Party (Specify):
Other Party (Specify):	Other Party (Specify):

Subscribed and sworn to before me
this _________ day of ______________________
Notary Public ______________________________
My Commission expires ______________________

____
Signature