cid management

CID Appeal/Reconsideration Request

Use of this form to initiate an appeal/reconsideration of a prior non-certification [denial] of medical goods or services is optional.

Date: _____

Name of injured worker: _____

Claim number: _____

Date of injury: _____

Review to be appealed (date and/or review #): _____

Person requesting appeal: _____

Relationship to injured worker: _____

Denied service(s) to be appealed:

Basis/reason for disagreement with prior adverse determination:

Additional documents attached (Y/N): _____
Number of pages attached: _____

Written request for appeal may be mailed or faxed.

Mailing address: CID Management
PO Box 4379
Westlake Village, CA 91359

Fax: 877-628-6724

June 2014