State of Colorado

Office of Administrative Courts

☐ 1525 Sherman St., 4th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us

☐ 1330 Inverness Drive, Suite 330, Colo. Springs, CO 80910 Email: oac-csp@state.co.us

☐ 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us

_____

Claimant,

v.

_____

Employer/Respondent, and

_____

Insurer/Respondent.

▲ **Court Use Only** ▲

WC Number:

_____

Date of Injury:

_____

Application For Expedited Hearing

You must complete all sections of Application (Sections A, B, C, & D)

A. Grounds for Expedited Hearing

Check appropriate box and fill in blanks for all applicable grounds for an expedited hearing.

☐ The Respondents have filed a Notice of Contest within the previous 45 days on (*date*) _____ and the Claimant requests an expedited hearing on compensability and medical benefits. (*You must attach a copy of the Notice of Contest*). Sections 8-43-203(1)(a), & 8-42-105 (2)(a), C.R.S.

☐ There is an urgent need for prior authorization of health care services, as recommended in writing by _____, an authorized treating provider, and prior authorization has been denied. (*You must attach a copy of the recommendation of the authorized treating provider*). Rule 16-7-2.E, WCRP.

☐ The Respondents have filed a Petition to Suspend, Modify, or Terminated Compensation on (*date*) _____ and the Claimant filed an objection to the Petition on (*date*) _____. (*You must attach a copy of the Petition and objection*). Rule 6-4, WCRP.

☐ The Claimant provided the Employer with notice of an alleged injury or injuries within the previous 45 days on (*date*) _____. The _____ (*Claimant or Respondents*) request an expedited hearing on the issue of whether the Employer or Insurer provided a list of medical providers/physicians in compliance with section 8-43-404(5), C.R.S.

☐ The Insurer or Self-Insured Employer filed an initial admission of liability for the claim within the previous 45 days on (*date*) _____. The _____ (*Claimant or Respondents*) request an expedited hearing on the issue of whether the Employer or Insurer provided a list of medical providers/physicians in compliance with section 8-43-404(5), C.R.S.

☐ The Insurer or Self-Insured Employer admitted liability within the previous 45 days on _____ (*date*) which included a reduction of compensation pursuant to section 8-42-112, C.R.S. _____ (*Claimant or Respondents*) request an expedited hearing on the issue of whether the Employer or Insurer may reduce compensation.

☐ The Insurer or Self-Insured Employer terminated temporary total disability benefits within the previous 45 days on (*date*) _____ because the claimant was released to regular employment and there is a dispute under section 8-42-105(5), C.R.S., as to whether the benefits were properly terminated.

☐ An Expedited Hearing is requested pursuant to Rule 8-5(C), Workers' Compensation Rules of Procedure (*check all that apply*):

- ☐ Claimant has requested a one-time change of physician (*You must attach a copy of the notice*.);
- ☐ Insurer has provided a written objection within 7 business days of the request (*You must attach a copy of the written objection*.);
- ☐ There exists a factual dispute requiring a hearing. (*State below the factual dispute(s) that exist*).

_____

_____

The opposing party may file a response to this Application for Expedited Hearing within 10 days of the mailing or delivery of this Application for Expedited Hearing

Witnesses to be called at the hearing or by deposition (List names and addresses):

	Name	Address
1.		
2.		
3.		
4.		

(Attach additional pages as necessary)

B. Setting Case for Hearing

The Office of Administrative Courts will set this case for hearing and will send a written Notice of Hearing to the parties.

C. Signature of Party or Attorney

X _____ _____

Signature | Attorney Registration Number (if applicable)

First Name:		Last Name:	
Company:			
Address:			
City:	State:	Zip:	Phone:
E-mail:			

D: Certificate of Service or Mailing

I hereby certify that I mailed or delivered true and correct copies of the Application for Expedited Hearing to all parties at the addresses shown below: (*A claimant must provide a copy to the employer and the insurer, or their attorney*.)

Party 1	First Name:		Last Name:	
	Company:			
	Address:			
	City:	State:	Zip:	Phone:
	E-mail:			
Party 2	First Name:		Last Name:	
	Company:			
	Address:			
	City:	State:	Zip:	Phone:
	E-mail:			

_____ _____

Signature of person serving document | Date served