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| State of Colorado | 🟂 **Court Use Only** 🟂 |
| Office of Administrative Courts |
| [ ]  1525 Sherman St., 4th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us[ ]  2864 S. Circle Dr, Ste 810, Colo. Springs, CO 80906 Email: oac-csp@state.co.us[ ]  222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us |
|  |  |  |
| Claimant, |
| v. | **WC Number:** |
|  |  |  |  |  |  |
|  | Employer/Respondent, and |  |  |
|  |  |  | **Date of Injury:** |
|  | Insurer/Respondent. |  |   |  |  |
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| **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*).  |
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|  | **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. |

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| **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:  |

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| **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 | Revised 5/25 |