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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. | | | | | |  |  |  | | |  |
|  | | | | | | | |  | | | | |
| **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 |