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| STATE OF COLORADO | | | | | | | |  | | | |
| OFFICE OF ADMINISTRATIVE COURTS | | | | | | | |
|  | | 1525 Sherman Street, 4th Floor, Denver, CO 80203 [OAC-DVR@state.co.us](mailto:OAC-DVR@state.co.us) | | | | | |
|  | | 2864 S. Circle Dr., Suite 810, Colo. Springs, CO 80906 [OAC-CSP@state.co.us](mailto:OAC-CSP@state.co.us) | | | | | |
|  | | 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 [OAC-GJT@state.co.us](mailto:OAC-GJT@state.co.us) | | | | | |
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| Claimant, | | | | | | | |
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|  | | | | | | | | 🟂 **COURT USE ONLY** 🟂 | | | |
| vs. | | | | | | | | **WC NUMBER:** | | | |
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|  |  | | | | | |  | **DATE OF INJURY:** | | | |
| Respondent. | | | | | | | |  |  | |  |
|  | | | | | | | |  | | | |
| **APPLICATION FOR EXPEDITED HEARING** | | | | | | | | | | | |
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| Complete Section A, B, C, D, E, F or G. | | | | | | | | | | | |
|  | | | | | | | | | | | |
| A. | | | 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). Section 8-43-203(1)(a), C.R.S. | | | | | | | |  |
|  | | | | | | | | | | | |
| B. | | | 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 16-10, WCRP. | | | | | | | |  |
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| C. | | | 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. | | | | | | | |  |
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| D. | | | 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. | | | | | | | |  |
|  | | |  | | | | | | | |  |
| E. | | | 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. | | | | | | | |  |
|  | | |  | | | | | | | |  |
| F. | | | 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. | | | | | | | |  |
|  | | |  | | | | | | | |  |
| G. | | | 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. | | | | | | | |  |
| **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.** | | | | | | | | | | | |
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| Witnesses to be called at the hearing or by deposition: List names and addresses: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | (Attach additional pages if necessary) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **X** |  | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | |  |
|  | Signature | | | | | | | | | | | | | | | | | | | | | | | |  | | Attorney Registration Number (if applicable) | | | | | | | | | | | | | |  |
| First Name | | | |  | | MI: | |  | | | | Last Name | | | | | | | | |  | | | | | | | | | | | | | | Suffix | |  | | |  | |
| Company | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| City | | | |  | | | | | | | State | | | |  | | | | Zip | | | | |  | | Phone | | | | |  | | | | | | | | |  | |
| E-mail | | | |  | | | | | | | | | | | | | | | | Signor is: | | | | | | | |  | | | | | | | | | | | |  | |
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| 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 | |  | | MI | | |  | | | Last Name | | | |  | | | | | | | | | | | | | | | | | Suffix | |  | | |  | | | |
| Company | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| City | |  | | | | State | | | | |  | | | | Zip | | | |  | | | | | | | | | | Phone |  | | | | | |  | | | |
| E-mail | |  | | | | | | | | | | | Recipient is the: | | | | | | | | | | | | | |  | | | | | | | | |  | | | |
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| Party 2 | | | First Name | |  | | MI | |  | | | | Last Name | | | |  | | | | | | | | | | | | | | | | | Suffix | |  | | |  | | | |
| Company | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| City | |  | | | | State | | | | |  | | | | Zip | | | |  | | | | | | | | | | Phone |  | | | | | |  | | | |
| E-mail | |  | | | | | | | | | | | Recipient is the: | | | | | | | | | | | | | |  | | | | | | | | |  | | | |
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|  | | | Signature of person serving Application | | | | | | | | | | | | | | | | | | | |  | | | | | | Date served | | | | | | | | | Rev 9/23 | | | | |