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| STATE OF COLORADO |  |
| OFFICE OF ADMINISTRATIVE COURTS |
| [ ]  | 1525 Sherman Street, 4th Floor, Denver, CO 80203 OAC-DVR@state.co.us |
| [ ]  | 2864 S. Circle Dr., Suite 810, Colo. Springs, CO 80906 OAC-CSP@state.co.us |
| [ ]  | 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 OAC-GJT@state.co.us |
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| Claimant, |
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|  | 🟂 **COURT USE ONLY** 🟂 |
| vs. | **WC NUMBER:** |
|  |  |  |  |  |  |
|  | Employer, |  |  |
|  |  |  | **DATE OF INJURY:** |
| Respondent. |  |  |  |
|  |  |
| **APPLICATION FOR EXPEDITED HEARING** |
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| Complete Section A, B, C, D, E, F or G. |
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| 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. |  |
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| 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. |  |
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| 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. |  |
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| 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. |  |
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| 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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| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
|  | (Attach additional pages if necessary) |  |
|  |
|  |
|  |
| **X** |  |  |  |  |
|  | Signature  |  | Attorney Registration Number (if applicable) |  |
| First Name |  | MI: |  | Last Name |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone  |  |  |
| E-mail |  | Signor is: |  |  |
|  |
| 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: |  |  |
|  |
| Party 2 | First Name |  | MI |  | Last Name |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone |  |  |
| E-mail |  | Recipient is the: |  |  |
|  |  |
|  |  |  |  |  |
|  | Signature of person serving Application |  | Date served | Rev 9/23 |