Form 112
October 2016 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Medical Dispute
Claim No. ____________________
Before: ________________________________

	vs.	
Plaintiff/Employee		Defendant/Employer (business name)
Social Security Number/Green Card		Mailing Address
Birth Date		City/State/Postal Code
Mailing Address		Insurance Carrier
City/State/Postal Code		Mailing Address
Country		City/State/Postal Code
Occupation		

* Date of injury / last exposure: _____________

* Cause of Injury: ______________________________ * Nature of Injury: ____________________________

* Body part affected: _____________________________

Medical Provider:

Name

Mailing Address

City State Postal Code

Medical Provider:

Name

Mailing Address

City State Postal Code

Medical Provider:

Name

Mailing Address

City State Postal Code

Medical Provider:

Name

Mailing Address

City State Postal Code

* Comes ___________________________________ and requests resolution of a medical dispute, and states as follows. This party is the:

☐ Employee ☐ Insurance Carrier
☐ Employer ☐ Medical Provider

* Has a workers' compensation claim been filed with the Department of Workers' Claims?
☐ Yes ☐ No If yes, please provide claim number ______________

* A utilization review has been completed.
☐ Yes ☐ No

If no, please explain why a utilization review is not required by 803 KAR 25:190 in this claim:
____

____

NOTE: If utilization review is required by 803 KAR 25:190, no Medical Dispute may be filed prior to exhaustion of that process.

The date(s) on which each disputed statement for services was first received by the employer, insurance carrier or any agent thereof is as follows:

Description	Date First Received

NOTE: A copy of all disputed statements for services must be attached hereto, including all required documentation.

* The nature of this dispute can be briefly described as follows: (Please include all facts necessary for relief sought and attach copies of any supporting medical documentation.)
____

____

* Has an award or settlement previously been entered on this claim? ☐ Yes ☐ No

If yes, date of award or settlement: _____________________

The following supporting documents are attached:

☐ Copy of the final utilization review decision
☐ Physician opinion supporting utilization review decision
☐ Medical bill audit, if any
☐ Copies of disputed statements for services
☐ Supporting medical documentation

For reopening a claim to contest this medical treatment, the following additional items are attached:

☐ Motion to Reopen
☐ Affidavit(s)
☐ Medical report
☐ Current medical release Form 106 signed and witnessed
☐ A copy of the Opinion and Award, Settlement, Agreed Order or Agreed Resolution sought to be reopened

Submitting Party:

* Name ____ Role ________________________

* Mailing Address ____

Mailing Address ____

* City / State / Postal Code ____

This information is true and accurate according to my knowledge and belief.

____
Signature

A copy of this filing has been sent to the following recipients: