File this form with the Department of Labor and Industry at the address or fax number at the end of this form.

# Medical Response

Reset

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

MR03

DO NOT USE THIS SPACE

**THIS FORM RESPONDS TO ISSUES RAISED ON THE MEDICAL REQUEST FORM SIGNED ON** _____(date)

| WID or SSN | DATE OF INJURY |
|---|---|
| EMPLOYEE NAME | PHONE # (include area code) |

| EMPLOYEE ADDRESS | | | INSURER/SELF-INSURER/TPA | | |
|---|---|---|---|---|---|
| CITY | STATE | ZIP CODE | INSURER ADDRESS | | |
| EMPLOYER NAME | | | CITY | STATE | ZIP CODE |
| EMPLOYER ADDRESS | | | CLAIM REPRESENTATIVE NAME | | |
| CITY | STATE | ZIP CODE | INSURER CLAIM # | INSURER PHONE # | EXT |

**INSTRUCTIONS:**

- All parties are expected to try to resolve issues themselves, using the Department of Labor and Industry to settle disputes only when these attempts fail.
- This form must be filled out completely.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- You must complete this response form and send it to the address on the back of this form within 20 days of the date you received the Medical Request.

**I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.**
**For more information, call the Alternative Dispute Resolution Unit at (651) 284-5032 or 1-800-342-5354.** ☐ **YES** ☐ **NO**

1. **THIS RESPONSE IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ Health Care Provider

2. The employee has not exhausted the dispute resolution process of the certified managed care plan. The employee may contact _____ at _____ (phone) to initiate this process.

Name of the Certified Managed Care Plan _____

3. **RESPONSE TO ISSUES RAISED ON REQUEST FORM (check only those that apply)**

☐ a. I respond to the request for payment of medical or chiropractic bills as follows: (List the health care providers and your response to the specific bill amounts listed on the Request form. Attach extra sheets if needed).

| HEALTH CARE PROVIDER | ALREADY PAID | AGREE TO PAY | REFUSE TO PAY |
|---|---|---|---|
| | | | |
| | | | |

b. I ☐ agree ☐ disagree with the request to change treating doctors.

c. I ☐ agree ☐ refuse to pay for the requested treatment, surgery or equipment.

d. I ☐ agree ☐ refuse to reimburse the employee for medical expenses.

e. I ☐ agree ☐ disagree with the request for a second opinion or consultation.

f. Response to "Other":

**YOU MUST COMPLETE # 4 BELOW IF YOU DISAGREE WITH ANY PART OF THE REQUEST.**

4. Explain why you disagree with the request and why it should not be granted. Attach extra sheets if necessary. You must attach medical reports, QRC/vendor reports or other documents which are needed to support your position. A written decision may be based solely upon review of this form, its attachments, the Workers' Compensation Division file, and the Medical Request form.

   **Specify any applicable treatment parameter(s): Minn. Rule 5221.** _____

5. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, health care provider, and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

| NAME | ADDRESS | CITY, STATE, ZIP CODE |
|---|---|---|
| NAME | ADDRESS | CITY, STATE, ZIP CODE |
| NAME | ADDRESS | CITY, STATE, ZIP CODE |
| NAME | ADDRESS | CITY, STATE, ZIP CODE |
| NAME | ADDRESS | CITY, STATE, ZIP CODE |
| NAME | ADDRESS | CITY, STATE, ZIP CODE |

I sent a copy of this form and all attachments to the parties listed in #5 on _____ (date)

| PRINT NAME OF PERSON FILING THIS RESPONSE | | | SIGNATURE | | |
|---|---|---|---|---|---|
| ADDRESS | | | ATTORNEY REGISTRATION # | | |
| CITY | STATE | ZIP CODE | PHONE # (include area code) | EXT | DATE SIGNED |

| WHEN YOU HAVE FULLY COMPLETED THIS FORM, RETURN IT AND ALL ATTACHMENTS TO: | **In person:**<br>MN Department of Labor and Industry<br>Workers' Compensation Division<br>443 Lafayette Road N.<br>St. Paul, MN 55155 | **Mailing address:**<br>MN Department of Labor and Industry<br>Workers' Compensation Division<br>443 Lafayette Road N.<br>St. Paul, MN 55155 |
|---|---|---|

***Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.***

***This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354.***

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**