

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS

1525 Sherman Street, 4th Floor, Denver, CO 80203 Fax: (303)866-5909
1259 Lake Plaza Drive, Suite 230, Colo. Springs, CO 80906 Fax: (719) 576-2978
222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Fax: (970) 248-7341

Claimant,

vs.

Employer, and

Respondent.

▲ COURT USE ONLY ▲

WC NUMBER:

DATE OF INJURY:

APPLICATION FOR EXPEDITED HEARING

Complete Section A, B, or C

- 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. (Attach a copy of the Notice of Contest). Section 8-43-203(1)(a), C.R.S.; or
- 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. (Attach a copy of the recommendation of the authorized treating provider). The claimant requests an expedited hearing. Rule 16-10, WCRP; or
- 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) _____. The Respondents request an expedited hearing. (Attach a copy of the Petition and objection). Rule 6-4, WCRP.

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:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

(Attach additional pages if necessary)

Request for the OAC to Set the Matter for Hearing (Rule 8(H) OACRP):

If you are not represented by an attorney and would like the Office of Administrative Courts to set this case for you, please check here:

X

Signature _____

Attorney Registration Number _____

First Name _____ Last Name: _____ Middle Initial _____ Suffix _____
 Company _____
 Address _____
 City _____ State ____ Zip ____ Phone _____
 E-mail _____

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.):

Claimant/Respondent or their Representative:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____
	Company _____
	Address _____
	City _____ State ____ Zip ____ Phone _____
	E-mail _____

Employer or their Representative:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____
	Company _____
	Address _____
	City _____ State ____ Zip ____ Phone _____
	E-mail _____

Other:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____
	Company _____
	Address _____
	City _____ State ____ Zip ____ Phone _____
	E-mail _____

Signature _____

Date Mailed _____

REV 11/13