

Instructions for Completing the Notice of Contest

Please read all pages

This form is “**fillable**.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the “TO” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security # and Phone #. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. To fill in a **check box**, click inside the box with your mouse. The “Certificate of Mailing” fields are surrounded by a **gray border**. Type the information in the first field and tab to the next to enter more information.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE OF CONTEST

Clear Entire Form

WC # _____
Social Security # _____
Date of Injury _____
Insurer Claim # _____
Insurer Name _____
Employer Name _____

**“Check Box”
Click in Box**

Pursuant to Section 8-43-203, C.R.S., the undersigned employer or insurance carrier hereby notifies the claimant and the Division of Workers' Compensation that liability for the following reason:

**“Clear Entire Form” button
Clears all information at once**

Further Investigation for _____
 Injury/Illness Not Work-Related _____
 No Insurance Coverage _____
 Third-Party Involvement _____
 Other (please describe) _____

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Claim Representative _____ Phone # _____

Address **“Gray Border”** **Enter information and tab to next field** _____

CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____, _____.

List names and addresses of all persons copied:

Claimant: _____

Claimant's Attorney: _____

Employer: _____

Carrier's Attorney: _____

Division of Workers' Compensation, 1515 Arapahoe Street, Denver, CO 80202-2117

Block #	Adj. Code

By: _____

Clear Entire Form

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11:44 AM
Tuesday
5/27/2003

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE OF CONTEST

TO: _____ _____ _____	WC # _____ Social Security # _____ Date of Injury _____ Insurer Claim # _____ Insurer Name _____ Employer Name _____
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Pursuant to Section 8-43-203, C.R.S., the undersigned employer or insurance carrier hereby notifies the claimant and the Division of Workers' Compensation that liability for the above-referenced claim is contested/denied for the following reason:

Further Investigation for _____
Injury/Illness Not Work-Related _____
No Insurance Coverage _____
Third-Party Involvement _____
Other (please describe) _____

NOTICE TO CLAIMANT:

You may request an expedited hearing on the issue of compensability by filing an **Application for Hearing and Notice to Set and a Request for Expedited Hearing** with the Office of Administrative Courts. These forms must be filed within 45 days from the date of mailing on this Notice of Contest. If you don't file within 45 days, the hearing will be set within the usual time limits. You may call the Office of Administrative Courts in Denver at 303.866.2000, in Grand Junction at 970.248.7340, or in Colorado Springs at 719.576.2958, to obtain the forms.

Claim Representative _____ Phone # _____
Address _____

CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____, _____.

List names and addresses of all persons copied:

Claimant:
Claimant's Attorney:
Employer:
Carrier's Attorney:

Division of Workers' Compensation: (Only electronic filing accepted.)

By: _____

Block #	Adj. Code

INSTRUCTIONS / DEFINITIONS

Type or print legibly.

TO: List the name and address of the injured worker to whom the Notice of Contest is mailed.

WC#: List the Workers' Compensation number assigned by the Division to the claim.

Social Security #: List the Social Security number of the claimant.

Date of Injury: List the date of injury associated with the claim.

Insurer Claim #: List the claim number assigned by the carrier or self-insured to the claim.

Insurer Name: List the name of the carrier or self-insured associated with the claim.

Employer Name: List the name of the employer associated with the claim.

Reason for Contesting Claim: Check only **ONE** reason for contesting the claim. If "Further Investigation" is checked, list the reason for the investigation. If "No Insurance Coverage" is checked, a reason can be listed. Use "Other" only if a listed option does not apply. If "Other" is checked, include a description.

Claim Representative: List the name of the individual claim adjuster who manages the claim.

Phone #: List the telephone number, including area code, of the claim representative.

Address: List the mailing address of the claim representative.

Certificate of Mailing Date: List the day, month, and year that this Notice of Contest was placed in the U.S. mail or delivered to the claimant and other parties. The date mailed and the date the form is completed are not always the same date.

Names and Addresses: List the name and mailing address of each party to the claim to whom this Notice of Contest was mailed or delivered. Space is provided for the claimant, claimant's attorney, employer, carrier's attorney, and the Division of Workers' Compensation. Complete name and address as appropriate.

The Division's copy of the Notice(s) of Contest is required to be filed electronically. All other parties' copies must be mailed.

By: The claim representative completing the form must sign the form as a representative of the carrier or self-insured attesting to the validity of the certification date.

Block #: List the block number assigned to the carrier or self-insured associated with the claim.

Adj. Code: If applicable, list the adjuster code assigned to the third party administrator adjusting the claim.

Division of Workers' Compensation
633 17th St., Suite 400
Denver, CO 80202-3626
303.318.8700