COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE OF CONTEST

TO: _____
Claimant's Name

_____
Claimant's Address

_____
Claimant's Address

and
DIVISION OF WORKERS' COMPENSATION

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

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
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