COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, 4th Floor | Denver, CO 80202-3626
Phone: (303) 318-8700
Fax: (303) 318-8758

MEDICAL BILLING DISPUTE RESOLUTION INTAKE FORM

Name of Contacting Party: _____
Title: _____
Mailing Address: _____
Email Address: _____
Phone: ( ) _____ Fax: ( ) _____

Provider/Payer Initiating Dispute: _____
NPI or Tax ID#: _____
Other Party Involved in Dispute: _____

Claimant: _____ Date of Service: _____
Employer: _____

Dollar Amount in Dispute:

- Payment you received: $ _____
- Payment you feel you should have received: $ _____
- Explain how you arrived at this amount:

_____

Have you followed the procedures in Rule 16-11(D)? ☐ Yes ☐ No
If not, why? _____

Issue(s) in Dispute (check all that apply):

☐ Rule
☐ CPT
☐ PPO Contract
☐ UCR
☐ Supply
☐ Other _____

Please provide a detailed explanation of the dispute:

What actions have you taken to resolve this dispute? *(include person(s) you spoke with and dates if available)*

Please attach all supporting documents that are applicable in your dispute:

☐ Original bill
☐ EOB(s)/EOR(s)
☐ Prior authorization
☐ Invoice(s)
☐ Appeal(s)
☐ Office/procedure/operation notes
☐ Call logs/emails
☐ Correspondence from other party
☐ Copy of request for contract