

Department of Labor and Industry  
 Workers' Compensation Division  
 Benefit Management and Resolution Unit  
 PO Box 64218  
 St. Paul, MN 55164-0218  
 (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)  
 Fax: (651) 284-5727

# Request for Certification of Dispute

PRINT IN INK or TYPE  
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

*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.*

WID or SSN		DATE OF INJURY	
EMPLOYEE NAME			
EMPLOYER NAME		INSURER/SELF-INSURER/TPA	
INSURER ADDRESS		CITY	STATE ZIP CODE
CLAIM REPRESENTATIVE NAME		INSURER CLAIM #	
INSURER PHONE #	EXT.	INSURER FAX #	Part(s) of body injured:

Have more than 3 days of work been missed because of this injury?

YES  NO

If medical services are disputed, are they being provided or managed by a certified managed care plan?

YES  NO

If Yes, attach information showing that the dispute procedure of the managed care plan has already been exhausted (per 176.1351, subd. 3).

Nature of the rehabilitation or medical dispute (if there are unpaid medical bills, itemize below):

HEALTH CARE PROVIDER NAME	SERVICE DATE(S)	\$ AMOUNT	DATE BILL SUBMITTED TO INSURER
	-		
	-		
	-		
	-		

Reason insurer has denied (if known):

PRINTED NAME AND TITLE		PHONE #	EXT.
ADDRESS		FAX #	
CITY	STATE	ZIP	DATE SUBMITTED