

**KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
657 CHAMBERLIN AVENUE, FRANKFORT, KY 40601**

Request for Expedited Medical Determination

Claim No. _____

Filed:

Plaintiff

vs.

Defendant/Employer (Business Name)

Social Security Number/ Green Card

Defendant/ Employer Mailing Address

Birth Date Gender

City/State/Postal Code

Plaintiff Mailing Address

Insurance Carrier

City/State/Postal Code

Insurance Carrier Mailing Address

Outside United States

City/State/Postal Code

Country

**Requesting Party if other than Plaintiff/Employee or
Defendant Employer**

Phone Number

Name

Mailing Address

City/State/Postal Code

Additional Defendants

Additional Defendant

Additional Defendant

Mailing Address

Mailing Address

City/State/Postal Code

City/State/Postal Code

Reason for Joinder:

Reason for Joinder:

Injury Information

Date of Accident/Injury	Nature of Injury
Body Part Injured	Plaintiff Role

Comes the Plaintiff/employee, Defendant/Employer or other requesting Party and seeks an expedited medical determination by an Administrative Law Judge of entitlement to and payment for medical treatment.

In support of this motion, the following documents are attached:

- Affidavit establishing the plaintiff/employee is eligible for benefits. Under KRS Chapter 342, was an employee of the defendant employer at the time of injury, describing to whom and in what manner notice of the injury was given, and that irreparable injury, loss or damage will result if the requested medical treatment is not approved and payment of medical expenses is not granted.

- Medical Report of Dr. _____ supporting entitlement to medical treatment requested and the impact of failure to receive and expedited decision.

Based upon the foregoing, _____ moves for the appropriate relief.
Plaintiff/Employer, Defendant/Employer, or Other Requesting Party

Attestations:

- I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

Respectfully Submitted,

Plaintiff/Employer Signature or Movant

Plaintiff/Employer's or Movant's Mailing Address

Plaintiff/Employer's or Movant's City/State/Postal Code

Plaintiff/Employer's or Movant's Email Address

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact commits a fraudulent insurance act, which is a crime.

Certificate of Service

I certify the original of the foregoing document was filed with the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 by either U.S. Mail or electronically through the Department of Workers' Claims Litigation Management System and copies served on the persons or entities given below: