

Application for Dispute Resolution Exam



UCWCP

Union Construction Workers' Compensation Program
Administered by Wilson-McShane Corporation
www.ucwcp.com

Employee Name	Telephone	Email
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Street Address	City	State	Zip
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WID #	Date of Injury/Illness	Insurer/TPA Claim #
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Treating Physician	Clinic	Specialty of all Providers
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Treating Physician	Clinic	Specialty of all Providers
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Accepted injuries/Conditions

Denied injuries/Conditions

Reason for the Exam:

Parties:

Name, address and telephone number of all parties:

Employer Name	Email	Telephone
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Insurer Name	Email	Telephone
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Applicant Attorney Name (if applicable)	Email	Telephone
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Defense Attorney Name (if applicable)	Email	Telephone
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QRC Name (if applicable)	Email	Telephone
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Submitting Party (Employee, Insurer, or Employer)	Telephone	Date
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Please email the completed form to agascoigne@wilson-mcshane.com and copy all parties to your request.
The Program will review your request and respond in 48 hours.