CORVEL CORPORATION
Florida Workers’ Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM
See Reverse Side of Form for Information Regarding Filing a Grievance

An Injured Worker or Health Care Provider may use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers’ Compensation Managed Care Arrangement.

This Grievance is Filed by: ___Provider ___Injured Worker or a Designated Representative: ___ Family Member ___ Attorney ___ Other

Date of Injury ____________________________________________________________

INJURED WORKER’S/ PROVIDER’S NAME: ________________________________________

Social Security Number

Address: ________________________________________________________________

Home Telephone: ____________________ Work/Alternate Phone _______________________

Contact if other than injured worker or provider ________________ Telephone# __________

PRIMARY CARE/TREATING PHYSICIAN: ______________________________________

Address: ________________________________________________________________

Office Telephone: __________________________________________________________

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this Grievance Being Filed? (Nature of the Problem):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Has a grievance been previously filed? ___YES___NO
IF YES Date sent? _________________________________________________________
What Action Would You Like to See Taken?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Have you received any information regarding your rights and responsibilities under WC Managed Care?
Yes_________No_________

**INTENT:** The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

**The injured worker's participation in the grievance process is important to the resolution of medical issues.** Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

**Exemptions:** The following items are specifically excluded from the grievance process: Indemnity Benefits; Vocational Benefits; MMI and Permanent Impairment; Medical Mileage Reimbursement; Provider Payments; Compensability; and Causation. Concerns regarding any of the issues listed above should be directed to the employer, adjuster, or the Florida Division of Workers' Compensation Employee Assistance Office at 1-800-342-1741.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers’ Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

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**MAIL TO:**

CorVel Corporation
Attn: Grievance Coordinator
725 Primera Blvd., Suite 220
Lake Mary, FL  32746
Telephone: (407) 805-0060 or (800) 229-4637
Fax: (407) 804-8775

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