Form 120EX
Expedited Determination
Revised May 1, 2008

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
657 CHAMBERLIN AVENUE
FRANKFORT, KENTUCKY 40601
CLAIM NO. _____

REQUEST FOR EXPEDITED DETERMINATION OF MEDICAL ISSUE

MOVANT	vs.	**RESPONDENT**
______ **Name**		______ **Name**
______ **Street Address**		______ **Street Address**
______ **City/State/Zip Code**		______ **City/State/Zip Code**

* *

PATIENT		**EMPLOYER**
______ **Name**	______ **Date of Injury**	______ **Name**
______ **Street Address**	______ **Social Security #**	______ **Street Address**
______ **City/State/Zip Code**		______ **City/State/Zip Code**

INSURANCE COMPANY

______
Name

______
Street Address

______
City/State/Zip Code

Comes the movant and request the Department of Workers' Claims to assign this request for expedited determination of medical issue to an Administrative Law Judge for a decision.

In support of this request, the movant files herewith sworn affidavit(s) showing work relatedness and medical necessity, and setting forth the nature of the dispute and facts sufficient to show that the movant is entitled to the relief sought.

This information is true and accurate according to my knowledge and belief.

Attorney for Movant (if represented)

______
Name

______
Street Address

______
City/State/Zip Code

____
Movant's Signature

Subscribed and sworn to before me this _____ day of __________________, 20_______

____
Notary Public Signature

My Commission Expires: ____________________________County: __________________

Note: The respondent and all other parties have 10 days in which to file a response pursuant to 803 KAR 25:012.

Copies of responses must be delivered to the Department of Workers' Claim, Attention: Case Files, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and to all parties.

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 fact material thereto commits a fraudulent insurance act, which is a crime.

CERTIFICATE OF SERVICE

As required by 803 KAR 25:012, copies must be served on all parties. I certify that true copies of this form and all attachments have been deposited in the United States mail today to the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601, and to the following individuals or entities:

Please list party, name and address

______
Party

______
Name

______
Street Address

______
City/State/Zip Code

______
Party

______
Name

______
Street Address

______
City/State/Zip Code

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Party

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Name

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Street Address

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City/State/Zip Code

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Party

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Name

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Street Address

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City/State/Zip Code

______
Party

______
Name

______
Street Address

______
City/State/Zip Code

______ ______________________________
Date **Movant's Signature**