Form 120EX
October 2016 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
500 MERO STREET, 3RD FLOOR,
FRANKFORT, KY 40601
Claim No. _____

Request for Expedited Medical Determination

_____
Plaintiff

_____
Phone

_____
Social Security Number/Green Card

_____
Birth Date Gender

_____
Mailing Address

_____
City/State/Postal Code

☐ Outside United States

_____
Country

_____
Defendant/Employer

_____
Mailing Address

_____
City/State/Postal Code

_____
Insurance Carrier

_____
Mailing Address

_____
City/State/Postal Code

_____
Additional Defendant Name

_____
Mailing Address

_____
City/State/Postal Code

_____
Additional Other Defendant

_____
Mailing Address

_____
City/State/Postal Code

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

_____

Name

Mailing Address

City/State/Postal Code

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 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 an expedited decision.

Based upon the foregoing, _____ moves for the appropriate relief.

Plaintiff/Employee, Defendant/Employer or Other Requesting Party

Respectfully submitted,

_____
Plaintiff/Employee Signature or Movant

_____
Plaintiff/Employee's Mailing Address

_____
Plaintiff/Employee's City/State/Postal Code

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.

I certify that the original was mailed or filed and served electronically through the Department of Workers' Claims Litigation Management System to the Department of Workers' Claims, 500 Mero Street, 3rd Floor, Frankfort, Kentucky 40601 and copies of this motion and attachments were served to the names and addresses of the parties given below:

_____

Plaintiff

Dedendants

Name	Address

_____

Carrier

Other Recipients

Name	Address

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.

_____

Plaintiff Signature

Instructions for Completion of Form 101 – <u>Application for Resolution of Injury Claim</u>

1. All sections of this form must be completed, and the following shall be filed within 15 days:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report describing and supporting the injury which is the basis of the claim.
   e. Proof of Wages, including W-2's, paycheck stubs, etc.

2. All information must be typewritten.

3. File the original of this form and sufficient copies for all named defendants with the **Department of Workers' Claims,** 500 Mero Street, 3rd Floor, Frankfort, Kentucky, 40601.

4. If you have no telephone number, please list a number at which you may be contacted.

5. If you have questions, call 1-800-554-8601.

Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.