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NOV 24 2008
SD DEPT. OF LABOR
DIV. LABOR & MGMT.

DISPUTE RESOLUTION FORM

DATE:	INITIATOR'S NAME:	INITIATOR'S PHONE #: ( )
CLIENT NAME:		EMPLOYER NAME:
INJURED WORKER'S NAME (FIRST, M, LAST):	DATE OF INJURY:	SSN#:
PROVIDER NAME (FIRST, M, LAST or Facility Name):	PROVIDER TITLE:	PROVIDER PHONE #: ( )
PROVIDER OR FACILITY ADDRESS (Street, City, State and Zip):		
PROVIDER OR FACILITY TAX ID #:	DATE OF DISSATISFACTION:	

Please describe your complaint in detail below. Include dates, names, and the specific resolutions which you feel might remedy the situation. PLEASE ATTACH COPIES OF APPLICABLE MEDICAL RECORDS TO THIS FORM.

THIS ISSUE INVOLVES: **Service** _____ **Medical Care** _____ **Other** _____

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REQUESTED ACTION:

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It is the goal of the case management plan to resolve this issue within 30 days of receipt of this form. At that time, should resolution not be achieved, or there continues to be dissatisfaction of the results, an appeal may be made to the South Dakota Department of Labor.

SIGNATURE:

FORWARD FORM TO: COVENTRY QI, COMPLAINTS & GRIEVANCES, 3200 HIGHLAND AVE. DOWNERS GROVE, IL 60516
E-mail: complaintsandgrievances@cvty.com
Phone Number 800-262-6122