DISPUTE RESOLUTION FORM

Date: _____

From:

Name: _____

Address: _____

_____

Telephone Number: _____

RE: Claimant Name: _____

Date of Injury: _____

Claim Number: _____

Employer: _____

Description and Summary of Dispute:

_____
_____
_____
_____
_____
_____

Please attach any supporting documentation that should be considered.

Please submit to: The Administrator of the Certified Case Management Plan
Jerry Gravatt
Stubbe Dakota Case Management
329-A East St. Joseph Street
Rapid City, SD 57701

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.