

CorVel Corporation
4101 S. Westport Ave., Suite A
Sioux Falls, SD 57106

DISPUTE RESOLUTION FORM

Date: _____

From:

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Regarding:

Claimant Name: _____

Date of Injury: _____

Claim Number: _____

Employer: _____

Description and Summary of Dispute: (attach written explanation) *Please attach any supporting documentation that should be considered.*

Please submit to: *Mary Jo Meyer at the above address.*

It is the goal of the case management plan to resolve this issue within thirty (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 and Regulation.