NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Sample Appeal Request Form RFP entitled: "Dispute Resolution Program"**

New York State Workers' Compensation Dispute Resolution Program Appeal Form

For Employees Eligible for the Medical Evaluation Program (MEP)

Instructions to Employee: Complete Part I of this form and immediately take it to your Treating Physician who must complete Part II. Your Treating Physician must return this form to National Medical Reviews, Inc. (NMR) within three (3) business days of notification by your Employing Agency to return to work. Failure to comply may result in leave without pay status. **You cannot file this appeal on your own behalf; this appeal form must also be completed and submitted to NMR by your Treating Physician.**

Part I: To be completed by Employee (Please print or type)

Date	**Date Notified to Return to Work**
Employee Name (first, middle, last)	**Social Security Number**
Home Address	**Home Telephone Number**
	SIF Carrier Case Number (Eleven digits) _____-_____
Employing Agency Name	**Work Address**
Work Phone Number	
Date and brief description of the injury/illness resulting in your Workers' Compensation claim: (ATTACH ADDITIONAL SHEETS)	
Employee Signature	**Negotiating Unit (NU):** **NU Code:**

Part II: To be completed by Employee's Treating Physician (Please print or type)

Instructions to Treating Physician: Complete Part II of this form and immediately return it with complete and comprehensive medical documentation that substantiates the employee's degree of disability. A NMR Physician will review the medical records and documentation sent by you and the Evaluation Physician and will render a determination in regard to the degree of disability that agrees with your determination or that of the Evaluation Physician. NMR must receive this completed form (including all necessary medical documentation) within three (3) business days of notification by the Employing Agency to the employee to return to work. Failure to comply may result in leave without pay status for the employee. **You may mail or fax completed forms and supporting documentation to:**

National Medical Reviews, Inc.
260 Knowles Ave, Suite 330
Southampton, PA 18966
Fax: (215) 352-7801 / Toll Free (866) 357-9045
Phone: (215) 352-7800 / Toll Free (800) 283-8196

Please follow all faxed copies with a copy by mail or overnight delivery.

Diagnosis: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]
Treatment Plan: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]
Prognosis: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]

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Estimated Degree of Disability:_____%

Treating Physician's Signature of Attestation:	**Address:**
Name: (Please print)	**Telephone Number: ( )**