CHECK BOX IF THIS REQUEST ADDS REHABILITATION ISSUES TO A PENDING REHABILITATION REQUEST ☐

Reset

Rehabilitation Request

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

RQ03

DO NOT USE THIS SPACE

NOTE: File this form with the Department of Labor and Industry at the address or fax number at the end of this form. Before filing this form, call the workers' compensation insurer or the Workers' Compensation Alternative Dispute Resolution Unit at (651) 284-5032 (or 1-800-342-5354).

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS			INSURER/SELF-INSURER/TPA		
CITY	STATE	ZIP CODE	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP CODE
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP CODE	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- This form must be filled out **completely**; otherwise, it may be **returned** to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, medical, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Alternative Dispute Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS REQUEST IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TP Self-insured ☐ Insurer's Attorney ☐ QRC/ Vendor

2. **REHABILITATION ISSUES (check only those that apply)**
I request:

☐ a. that rehabilitation services/consultation be provided. Attach medical report which lists restrictions.

☐ b. a change of QRC (qualified rehabilitation consultant):

FROM	NAME			NAME
	FIRM NAME		TO	FIRM NAME
	ADDRESS			ADDRESS
	PHONE # (include area code)			PHONE # (include area code)

☐ c. that the rehabilitation plan be changed.

☐ d. retraining or exploration of retraining.

☐ e. that the rehabilitation plan be terminated.

☐ f. that the rehabilitation plan be suspended.

☐ g. that the employee's rehabilitation expenses be reimbursed. Attach itemized bills and supporting documentation.

☐ h. that QRC/vendor bills be paid. Attach supporting QRC/vendor reports and itemized bills.

☐ i. other (explain)

3. Explain the details of your request. Attach all documents, such as medical reports and rehabilitation reports/bills, which support your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

4. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, QRC/vendor and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #4 on _____(date)

PRINT NAME OF PERSON FILING THIS REQUEST			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, RETURN IT AND ALL ATTACHMENTS TO:	**In Person:** MN Department of Labor and Industry Workers' Compensation Division 443 Lafayette Road N. St. Paul, MN 55155-4301	**Mailing Address:** MN Department of Labor and Industry Workers' Compensation Division PO Box 64221 St. Paul, MN 55164-0221	**Fax:** 651-284-5731

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342- 5354.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

DEPARTMENT OF LABOR AND INDUSTRY

Instructions for completing a Rehabilitation Request form

Submit a Rehabilitation Request form if you want to resolve a dispute about a workers' compensation rehabilitation issue. You must file the Rehabilitation Request form with the Department of Labor and Industry (department) at the address or fax number at the bottom of the form. Do not file the form with the Office of Administrative Hearings (OAH) – the department will send the Rehabilitation Request to OAH when OAH has jurisdiction under the workers' compensation law. The department may also send the dispute to OAH when authorized by law.

Do not use a Rehabilitation Request form if you also have a dispute about medical, wage loss or permanent partial disability benefits or if the insurer has denied liability for the entire workers' compensation claim (denial of primary liability). In these cases, you must use a Claim Petition form.

The qualified rehabilitation consultant (QRC) must file a Rehabilitation Request form to determine the direction of a plan when no other party has done so, and the QRC is unable to otherwise plan or implement rehabilitation services (unless the insurer has denied ongoing liability for the injury in writing).

Item 2 of the Rehabilitation Request form lists the most common rehabilitation issues in dispute. The following are some guidelines to help you put your dispute in a category.

a. **I request rehabilitation services/consultation be provided.** An injured worker or an employer/insurer may request a rehabilitation consultation/services. This is how you request for a QRC to help an injured worker to return to work or make a plan for how to find another job. One of the considerations about whether an injured worker receives rehabilitation services is if there are physical restrictions or a permanent partial disability caused by the work injury. Therefore, it is important to at- tach a doctor's report that describes the physical restrictions or permanent partial disability and indicates whether they are due to the work injury.

b. **I request a change of qualified rehabilitation consultant.** Only the injured worker or the employer/insurer may request a change of QRC. List the current QRC and the QRC to whom the injured worker wishes to change. Send a copy of the request and its attachments to both QRCs. If both the injured worker and the insurer agree to a change, there is no dispute and this form does not need to be submitted.

c. **I request the rehabilitation plan be changed.** An injured worker, an employer/insurer or a QRC may submit a request to change the rehabilitation plan. For example, an employee may submit a request to change the rehabilitation plan to look for work with a new employer when the insurer believes it is not necessary.

d. **I request retraining or exploration of retraining.** The employee, the employer/insurer or the QRC may submit a request on this issue. The employee may check this item to file a request for retraining under Minnesota Statutes 176.102, subd. 11 (c). The employee's request for retraining can be to change the rehabilitation plan to explore retraining or to request approval of a specific retraining plan. The QRC may check this item to seek approval of a rehabilitation plan amendment to explore retraining or for approval of a specific retraining plan.

e. I request the rehabilitation plan be terminated. The employee or the employer/insurer may request the rehabilitation plan be terminated. This could be requested when the employee no longer needs rehabilitation assistance or when there are other good reasons to end the plan. If the injured worker and the employer/insurer agree the QRC should close the plan, this form does not need to be
submitted. Insurers that request termination of the rehabilitation plan should send the employee a Rehabilitation Response form with the employee's copy of the Rehabilitation Request form.

f. I request the rehabilitation plan be suspended. The employee or the employer/insurer may request that the rehabilitation plan be suspended, rather than terminated. This could be requested when there is a temporary barrier to implementation of the plan, but the barrier is expected to resolve and the rehabilitation plan resume after a specified time or event.

g. I request the employee's rehabilitation expenses be reimbursed. An injured worker may request reimbursement for expenses she or he paid while carrying out the rehabilitation plan. Examples are mileage, parking, long-distance phone calls or day care while participating in the rehabilitation plan. This issue should be checked if these expenses have been submitted to the insurer and the insurer will not pay for them. Allow the insurer 30 days to consider the expenses before submitting a Rehabilitation Response form to the department.

h. I request QRC or job placement vendor bills be paid. The employee, a QRC or a job placement vendor may submit a request for payment of rehabilitation bills when the rehabilitation provider has properly submitted bills to the insurer and the insurer will not pay all or parts of the bills.

i. Other. Check this issue for any rehabilitation disputes not listed above. Describe the request.

Item 3. You must attach supporting documentation for your rehabilitation request. At times, the department may issue a legally binding written decision based on the information you submit on the Rehabilitation Request form and from the opposing party's information on the Rehabilitation Response form.

Therefore, it is important that you make your request as complete as possible. Attach supporting documentation, such as rehabilitation or medical reports, information or copies of bills that support your position.

If you do not provide documentation that supports your position, the department may notify you that your Rehabilitation Request form is incomplete and that no further action will be taken on the rehabilitation request until supporting documentation is submitted.

Item 4. You must list the names of all parties to the dispute and their addresses. You must send a complete copy of the request and all attachments to all parties to the dispute.

If you have questions about how to complete this form, call the Alternative Dispute Resolution unit at (651) 284-5032 in the Minneapolis/St. Paul metropolitan area or 1-800-342-5354 toll-free.

Besides resolving your dispute by filing this form, you may request mediation by one of the department's trained mediators who may be able to help you resolve your dispute. If you are interested in this less formal process, call the Alternative Dispute Resolution unit for more information.