Occupational Managed Care Alliance, Inc.

EMPLOYEE/PROVIDER GRIEVANCE FORM

This form is to be filled out by an employee or provider who is dissatisfied with an aspect of his/her treatment for an occupational injury or with a situation involving the OMCA managed care program. By completing this form, you are filing a grievance which will be reviewed and addressed by members of our administrative staff. Every effort will be made to accommodate reasonable requests. Please provide additional supporting documentation if available.

Please submit your written statement on the following lines within thirty (30) days of the occurrence of the event giving rise to the grievance. OMCA will render a written decision within thirty (30) days of receipt of this grievance.

FACILITY WHERE TREATMENT OCCURRED _____

NAME OF PROVIDER _____

DATE OF OCCURRENCE _____

COMPLAINT

I agree to allow OMCA's administrative staff to discuss my complaint with any parties involved.

Company Name _____

Your Name (please print) _____

Address _____
street address *city* *state* *zip*

_____ _____
Signature Date

PLEASE RETURN TO:
Occupational Managed Care Alliance, Inc.
ATTN: Client Services Department
P.O. Box 20908
Louisville, KY 40250-0908

Per KAR 25:110 Section 10 (5) (a) (b)
Any employee or provider dissatisfied with OMCA's resolution of a grievance may apply for review by an Administrative Law Judge by filing a request for resolution within thirty (30) days of the date of OMCA's final decision. Upon review by the ALJ, the movant shall be required to prove that OMCA's final decision is unreasonable or otherwise fails to conform with KRS chapter 342.

Department of Workers' Claims
Mayo-Underwood Building, 3rd Floor
500 Mero Street
Frankfort, KY 40601

Telephone (502) 564-5550