

Use this form if you intend to hand-deliver, mail, or fax your appeal. Don't send this form as an attachment to an email.

NOTICE OF APPEAL

Provider Appeals Only

If you disagree with a decision of the Department of Labor & Industries, this form can be used to file an appeal of that decision.

You must file the appeal with the Board of Industrial Insurance Appeals **WITHIN SIXTY DAYS** of the date you receive the Department's decision concerning a workers' compensation claim or your provider number or status.

You must file the appeal **WITHIN TWENTY DAYS** of the date you receive the Department's decision concerning demands for repayment or vocational audits.

Board of Industrial Insurance Appeals
2430 Chandler Court SW
PO Box 42401
Olympia, WA 98504-2401
FAX: 360-586-5611 or 855-586-5611

*** indicates required field**

1. ***Today's date:** _____

2. ***I wish to appeal the decision of the Department of L&I dated:** _____
Attach a copy of the decision to be appealed

3. Provider Information

*Name: _____			
Provider No.: _____			
*Address: _____			
City: _____	State: _____	Zip: _____	
Phone: _____	Email address: _____		

4. Worker Information (If applicable)

First Name: _____	Middle Name: _____	Last Name: _____
L&I Claim No.: _____		

5. Preparer Information (if different from above)

Preparer Name: _____	
Attorney Name _____	Bar No. _____
Firm Name _____	
Mailing Address: _____	
City: _____	State: _____ Zip: _____
Phone: _____	Contact Email Address: _____

6. I disagree with the Department's determination because:

7. Location

I desire to have any proceedings held in: _____ (County)

Print Name: _____

Signature: _____