City of Los Angeles Alternative Dispute Resolution (ADR) Program for Workers' Compensation Claims

Administered by California Claims Management Services, Inc.
21213-B Hawthorne Blvd. #5436
Torrance, CA 90503
Tel: (833) 505-2267
Fax: (310) 214-3095
Email: contact@adrlacity.org

Arbitration Request Form

Requested By: ________________________________ Request Date: ____________________

Employee: ____________________________________ Adjuster: _________________________

Claim #: _______________________________________ D.O.I.: ____________________________

Applicant Attorney:______________________________ AA Email: ________________________

Phone: (   ) _______ - _____________

Requested Dates For Arbitration:

1st Choice | 2nd Choice | 3rd Choice

Day:________ Time:______AM/PM Day:________ Time:______AM/PM Day:________ Time:______AM/PM

Note: *Arbitration shall be completed within sixty (60) working days from the date of the referral unless both the injured employee and City mutually agree to an extension.* Agreed to extension: ________________

Your Position Statement (details explaining the nature of the dispute) MUST be submitted with your request. Please also provide copies of medical reports and any and all additional documents that substantiate your position.

Medical Discovery completed? Yes/No

Is the IW P&S/MMI? Yes/No

Estimated WPI Rating _____%

Has a demand in writing been made? Yes/No

If employee will not be present at the arbitration, please advise with your proper cause prior to arbitration.

Please submit completed forms to contact@adrlacity.org or fax to (310) 214-3095