

APPENDIX A

DELAWARE DEPARTMENT OF LABOR
MEDICAL UTILIZATION REVIEW PROGRAM

REQUEST FOR UTILIZATION REVIEW
(Pursuant to 19 Del.C. §2322 F(j))

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION. All information and addresses must be verified as current and accurate.

1. Date of Request _____
2. WC Number(s) _____ Date(s) of injury _____
3. Nature of injury/Practice Guideline _____
4. Claimant's Name _____
Age _____ Sex _____ Marital Status _____
Address _____ Tel No _____
City _____ State _____ Zip _____
Attorney's Name _____
Address _____ Tel No _____
City _____ State _____ Zip _____
5. Employer _____ Occupation _____ Job Title _____
6. Party Requesting Review _____
Primary Contact at Party's Office _____
Address _____ Tel No _____
City _____ State _____ Zip _____

Attorney's Name _____
Address _____ Tel No _____
City _____ State _____ Zip _____
7. Health Care Provider to be Reviewed _____
Specialty (if applicable) _____
Address _____ Tel No _____
City _____ State _____ Zip _____
8. Attach copies of all admissions and/or orders filed or entered in this case.

My signature certifies the following: a) all names and addresses on this form have been verified as current and accurate; b) two identical copies of associated medical material are being submitted for review; and c) all items listed in the table of contents are in each copy of the medical material.

Print Name of Requester

Signature of Requester

**COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT
SEE INSTRUCTIONS ON BACK**

**REQUIRED CONTENT, PRESENTATION AND BINDING METHOD
FOR ALL MATERIALS SUBMITTED FOR UTILIZATION REVIEW**

In accordance with **19 Del.C. §2322 F(j)** and the regulations adopted pursuant thereto, all information and medical records submitted to the Department of Labor, Office of Workers' Compensation must represent all of the facts of this case.

INFORMATION PACKAGE - REQUIRED CONTENT

Completed and signed Request for Utilization Review Form.

A list containing the full names and medical specialties of all providers under review and individuals who performed defense medical examinations relevant to the matter under review.

Proof of date of issuance of claim denial (so the Department of Labor is able to verify that Utilization Review was requested within 15 days of the date of the claim denial).

MEDICAL RECORDS PACKAGE - REQUIRED CONTENT

1. Case Report - The case report shall contain the following:

- a Name, discipline of care and specialty of the Provider under review; date the provider first treated the claimant.
- b Claimant's standard demographic information (age, sex, marital status, etc.).
- c Claimant's employer and occupation/job title.
- d Date(s) and nature of claimant's work-related injury/exposure.
- e Date of initial treatment, a brief chronological history of treatment to the present date, and any significant contributing factors which may have had a direct effect on the length of treatment (e.g., diabetes).
- f Treatment to be reviewed (specify each treatment modality to be reviewed).

2. Table of Contents

- Section 1. A copy of the Employer's First Report of Injury.
- Section 2. All reports, notes, etc., from provider being reviewed as submitted to the requesting party.
- Section 3. All reports, notes, etc., of other treating providers as submitted to the requesting party.
- Section 4. All reports resulting from referrals, consultations, DME's and second opinions as submitted to the requesting party.
- Section 5. All diagnostic test results as submitted to the requesting party.
- Section 6. All medical management reports as submitted to the requesting party.
- Section 7. All hospital/clinic records related to the injury as submitted to the requesting party.

NOTE Do not include copies of any billing statements or comments/instructions directed to the Utilization Review panel. All material **must** be presented in identified sections; each section's content presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

INFORMATION PACKAGE - SUBMIT ONE COPY ONLY -- staple in upper-left-hand corner.

MEDICAL RECORDS PACKAGE - SUBMIT TWO (2) COPIES

- a. All submitted material must be presented in two (2) identical bound copies.
- b. If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to: **Department of Labor**
Office of Workers' Compensation
4425 N. Market St.
Wilmington, DE 19802
302-761-8200