

**APPENDIX A
DELAWARE DEPARTMENT OF LABOR MEDICAL
UTILIZATION REVIEW PROGRAM REQUEST FOR
UTILIZATION REVIEW**

(Pursuant to 19 Del.C. §2322F(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(s) _____
4. Claimant's Name _____ Age _____ Sex _____
Address _____ Tel. No. _____
City _____ State _____ Zip _____
5. Employer _____
6. Party Requesting Review ****Please view sentence (e) at the bottom of the page****
Requestor's Name & Organization _____
Email Address _____
Address _____ Tel. No. _____
City _____ State _____ Zip _____
7. Name of Claimant's Attorney _____
Address _____
8. Employer's Attorney _____ Email: _____
9. Health Care Providers to be Reviewed and other Health Care Providers Impacted by this Review:
(a) Health Care Provider to be Reviewed _____
Specialty (if applicable) _____
Date of first treatment _____
Address _____ Tel. No. _____
City _____ State _____ Zip _____
(b) Health Care Provider to be Reviewed _____
Specialty (if applicable) _____
Date of first treatment _____
Address _____ Tel. No. _____
City _____ State _____ Zip _____
(c) Additional Health Care Providers to be reviewed (list name, specialty, address, etc. on a separate sheet)
(d) Health Care Facility(s) Impacted (e.g. hospital, ambulatory surgery center, etc.) by this retrospective review (list name, address, etc. on a separate sheet)
10. Treatment to be reviewed: Specify the health care service to be reviewed and the timeframe within which the treatment was or will be rendered.

My signature certifies the following: (a) all names and addresses on this form have been verified as current and accurate; (b) one copy of associated medical material are being submitted for review; (c) the bill denial for the treatment subject to this review was sent within 30 days of receiving the provider's bill; and (d) all items listed in the table of contents are in each copy of the medical material and (e) the undersigned acknowledges and agrees that the party requesting this Utilization Review is financially responsible for all fees and costs associated with the review and payment of such fees shall not be contingent upon the outcome of the review.

Print Name of Requester

Signature of Requester

**COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT. SEE
INSTRUCTIONS ON BACKREQUIRED 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.
- If applicable, a list containing 1) names, addresses, etc. of the health care facilities impacted by this review; and 2) additional health care providers 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

- Section 1. All reports, notes, etc., from provider being reviewed from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, and the time frame within which the treatment to be reviewed was or will be rendered, as submitted to the requesting party.
- Section 2. All reports, notes, etc., of other treating providers from the date of injury or the one (1) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.
- Section 3. All diagnostic test results from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, 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 must be presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

- a. All submitted material must be presented in one (1) copy.
- 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
Medical Component Division
4425 N. Market St.
Wilmington, DE 19802