pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

QUALIFICATIONS OF REVIEWER

Reviewers are to submit completed forms to the Utilization/Peer Review Organization (URO). UROs will upload signed and dated forms in WCAIS after verifying the form's accuracy.

______________________________ (Reviewer Name)   ______________________________ (Reviewer Email)

PA State Licensing Board: ____________________ NPI: ____________________

If applicable, list any ABMS/AOA specialties currently held. 34 Pa. Code §127.652(a)(3)(iv). ☐ Not Applicable

Specialty: ____________________ Specialty: ____________________

1. List the total average number of hours worked each week. 34 Pa. Code §127.661. __________[1]

   a. Average number of hours per week solely dedicated to providing direct patient care in an active clinical practice.[2] __________ hours/week.

   b. Average number of hours per week dedicated to administrative, supervisory, managerial, and educational duties; speaking engagements; IME, IRE, UR; consults with other professionals; license/employment screenings; and other medicolegal type work. __________ hours/week.

   c. As a reviewer, please initial to confirm that you understand that hours associated with services identified in section (b) may ***not*** be included when determining compliance with the Act's requirement that reviewers perform at least 20 hours of active clinical practice per week. 34 Pa. Code §127.661(b). ________________

2. Mark the geographical area(s) where you practice your specialty. 34 Pa. Code §127.652(a)(3)(ii).

   ☐ Central PA ☐ Northeast PA ☐ Northwest PA ☐ Southeast PA ☐ Southwest PA

   Out of State Locations: ______________________________

3. Indicate your relationship with ______________________________ (Name of Utilization Review Organization). 34 Pa. Code §127.652(a)(3)(i).

   ☐ Employee ☐ Affiliate ☐ Entered into a Contract ☐ Entered into an Agreement

By my signature, I declare that I spend at least 20 hours per week treating patients in a clinical practice and meet the requirements set forth in 34 Pa. Code §127.661. I hereby state the information provided above and in any accompanying attachments is true and correct to the best of my knowledge, information and belief. I understand that any false statements contained on this Qualification of Reviewer form may be subject to prosecution under Article XI of the Act (relating to insurance fraud) or 18 Pa. C.S. §4904 (relating to unsworn falsification to authorities).

______________________________ (Signature of Reviewer)   __________ (Date)

URO Representative Only: By my signature, I verify that the URO received a completed QOR form signed by the reviewer, and to the best of my knowledge, information and belief, the form accurately reflects the provider's reviewer qualifications at the time of signing.

______________________________ (Signature of URO Representative)   __________ (Date)

______________________________ (Typed or Printed Name of URO Representative)

[1] UROs should verify these hours equal the number of hours in sections (a) and (b). Discrepancies may cause this form to be rejected.
[2] May include surgery, anesthesia, patient-centered telemedicine, and other face-to-face encounters performed by the provider to treat patients.

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program