

INSTRUCTIONS FOR COMPLETING UTILIZATION REVIEW REQUEST

Pursuant to the provisions of the Workers' Compensation Act (Act) and 34 Pa. Code Chapter 127 Medical Cost Containment Regulations, Utilization Review (UR) of all treatment provided by a health care provider under the Act may be subject to UR at the request of an employee, employer or insurer. Persons requesting a UR must provide all information requested on the attached Utilization Review request form. Please file electronically or complete this form carefully and accurately and MAIL the original UR request along with any attachments to:

Commonwealth of Pennsylvania Department of Labor & Industry
Bureau of Workers' Compensation Medical Treatment Review Section
1171 South Cameron Street, Room 310, Harrisburg, PA 17104-2597

Copies of the original UR request along with any attachments must also be mailed or electronically submitted to all parties (the employee, all providers under review, the insurer/employer and all counsel). **For any questions regarding the filing of the UR request, please contact the Medical Treatment Review Section at 717-772-1914.**

The UR request must be filled out completely. All information is required. Please enter "NONE" where appropriate. Please type or print clearly.

1. **Request filed on behalf of:** Check the appropriate box.
 2. **Employee Information:** Enter all requested information.
 3. **Attorney for employee:** Enter all requested information.
 4. **Employer information:** Enter all requested information.
 5. **Insurer or self-insured employer's third party administrator (TPA):** Enter all requested information including the NAIC code or Insurer code of the insurer or self-insured employer (available at www.dli.state.pa.us).
 6. **Attorney for insurer/employer:** Enter all requested information.
 7. **Provider(s) under review:** Enter the full name, complete address and telephone number of all providers who rendered or will render the treatment(s) or services(s) for which you are requesting UR. Remember that when the treatment or service to be reviewed is anesthesia incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the request for UR must identify the provider who made the referral, ordered or prescribed the treatment or service as the provider under review.
- Further, please note that you may only request review of individual providers (i.e., physician, chiropractors, etc.), and not facilities. While facilities are often "licensed" (i.e., hospitals, only the actual providers who treat patients may be reviewed. If the treatment which you wish to review constitutes a continuum of care, please identify all providers who rendered such treatment.
- Finally, if multiple providers rendered treatment under the direction or supervision of a provider with greater knowledge, education or responsibility for patient care, kindly identify both the individual providers and the directing/supervising provider.
8. **Treatment to be reviewed:** Specify ONLY the treatment or health care service to be reviewed (e.g. "Facet injections lumbar spine"), and identify the start date and end date of treatment(s) which you wish to submit to UR. If the end date is indeterminate, please enter "ongoing." If requesting a prospective review, simply state "prospective." Do not include any other information, such as billing issues, previous URs, or other comments which may influence a reviewer. Such comments will not be forwarded to a reviewer.
 9. **Billing dates for retrospective review:** A UR request must be filed within 30 days of the insurer/employer's receipt of the bill and medical report relating to the treatment under review. If you have not received a bill and/or medical report for the treatment under review or if this request is filed by the employee enter "none," otherwise, for each provider under review, enter the date upon which the insurer/employer received the bills and reports which represents the **start date** of treatment submitted for UR.
 10. **Payment pending WCJ decision:** If payment for the treatment under review was withheld pending a decision on a claim or reinstatement petition, please indicate provider(s), whose payment was withheld, and enter the circulation date of the decision awarding benefits.
 11. **Other treating providers:** If necessary on a separate sheet, enter the full name, license, specialty, complete address and valid telephone number of all other health care providers who rendered treatment or services for the work-related injury. Please do not include non-treating providers such as those who have performed independent medical examinations.
 12. **Act 46:** Check the box if this is an Act 46 (firefighter claim).
 13. **Proof of service:** Provide the date the UR request was signed and mailed to all parties. If you amend or "re-file" this request, you must update the Proof of Service Date.
 14. **Requesting party or representative:** Type or print your name, address and telephone number. You MUST sign the UR Request, or follow the online instructions to do so electronically.