pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

# UTILIZATION REVIEW REQUEST

The UR Request must be filled out completely (follow instructions): ALL INFORMATION IS REQUIRED.

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER ___ - ___ - ____ _____ DATE OF INJURY MM DD YYYY WCAIS CLAIM NUMBER _____

1. Filed on behalf of: ☐ Employee ☐ Insurer/Employer

2. **EMPLOYEE**

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____

3. **EMPLOYEE ATTORNEY**

Firm name _____
First name _____
Last name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

4. **EMPLOYER**

Employer name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

5. **INSURER OR SELF INSURED TPA**

NAIC code _____ or Bureau code _____
(*Required: See BWC Website for Bureau codes)
Insurer/TPA name # _____
Insurer claim # _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Claim rep name _____
Claim rep telephone _____

6. **INSURER/EMPLOYER ATTORNEY**

Firm name _____
First name _____
Last name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

****7-10 Provider Under Review/Treatment Information**
**Please see instructions**

**PROVIDER 1**
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start date _____ End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

**PROVIDER 2**
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start date _____ End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

**PROVIDER 3**

First name _____ Last name _____

Office address _____

City _____ State _____ ZIP _____

Telephone _____ License/Specialty _____

Treatment to be reviewed:

_____

Start date _____ End date _____ WCJ Circulation date _____

Bill rec'd _____ None ☐ Report rec'd _____ None ☐

**PROVIDER 4**

First name _____ Last name _____

Office address _____

City _____ State _____ ZIP _____

Telephone _____ License/Specialty _____

Treatment to be reviewed:

_____

Start date _____ End date _____ WCJ Circulation date _____

Bill rec'd _____ None ☐ Report rec'd _____ None ☐

**PROVIDER 5**

First name _____ Last name _____

Office address _____

City _____ State _____ ZIP _____

Telephone _____ License/Specialty _____

Treatment to be reviewed:

_____

Start date _____ End date _____ WCJ Circulation date _____

Bill rec'd _____ None ☐ Report rec'd _____ None ☐

(Pursuant to §127.404(b) the request for UR shall be filed within 30 days of receipt of the bill and report for the treatment at issue)

11. **Other Treating Providers:** If not filing electronically, please list any other treating providers for this claimant on additional sheet.
*Include first and last name, license and specialty, full address and telephone number for each provider.*

12. This is an Act 46 (firefighter cancer) claim ☐

13. **Proof of Service:** I hereby certify that on this day I have mailed a copy of this request to all parties and their attorneys, if known, including the provider(s) under review. ANY FALSE STATEMENT CONTAINED IN THIS UTILIZATION REVIEW REQUEST MAY BE THE SUBJECT OF PROSECUTION UNDER ARTICLE XI OF THE ACT (RELATING TO INSURANCE FRAUD), OR 18 Pa. C.S. §4903 (RELATING TO FALSE SWEARING).

14.

_____ Requesting Party or Representative's signature

_____ Requesting Party or Representative's name (typed/printed)

_____ Address

_____ City State ZIP

_____ Telephone number

_____ Email address

_____ Proof of Service date (MUST be updated if request is amended/re-filed)

NOTE: If not filing electronically, send the original to: Bureau of Workers' Compensation, Medical Treatment Review Section
1171 South Cameron Street, Harrisburg, PA 17104-2597

DO NOT attach deposition, medical records, IME reports or any other document not specifically requested to the UR Request Form. Any attachments not specifically requested will NOT be forwarded to the URO, and will NOT be returned. The Bureau will destroy/shred all attachments not requested.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).