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).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

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