pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION FOR REVIEW OF UTILIZATION REVIEW DETERMINATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ ____

DATE OF INJURY (MM - DD - YYYY)

__ - __ - ____

WCAIS CLAIM NUMBER

If the insurer/employer, employee or provider disagrees with the determination rendered against it by the URO, the insurer/employer, employee or provider may file this petition to request that a Workers' Compensation Judge review the URO's determination.

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Insurer/TPA claim # _____

Utilization Review Number: _____
(FROM THE UTILIZATION REVIEW DETERMINATION FACE SHEET)

URO name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

This request is filed by or on behalf of ☐ Employee ☐ Insurer/Employer ☐ Health Care Provider

ATTORNEY FOR INSURER/EMPLOYEE (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

ATTORNEY FOR INSURER/EMPLOYER (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

I hereby request that this petition be assigned to a Workers' Compensation Judge for a hearing to determine the reasonableness or necessity of the treatment provided by or prescribed by the health care provider below:

PROVIDER UNDER REVIEW

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

ATTORNEY FOR PROVIDER (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

NOTE: The 'treatment to be reviewed' and the 'dates of treatment' can be obtained from the UR Request form.

Treatment to be reviewed: _____

(NOTE: DO NOT USE PROCEDURE CODES TO IDENTIFY TREATMENT TO BE REVIEWED)

Date(s) of treatment to be reviewed: ☐☐ - ☐☐ - ☐☐☐☐

MM DD YYYY

I hereby certify that on this day I have mailed a copy of this petition to all parties and their attorneys, if known, including the provider whose treatment is under review.

_____ _____

Requesting Party or Representative's signature

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

Date ☐☐ - ☐☐ - ☐☐☐☐

MM DD YYYY

NOTICE: Petition will be returned if not signed and dated. Do not attach any documents to this petition. The Workers' Compensation Office of Adjudication will destroy all attachments and NOT forward them to the Workers' Compensation Judge and NOT return them to you.

NOTE: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N 7th Street, Suite 201, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A proof of service must be attached. A proof of service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.

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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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