DELAWARE MEDICAL UTILIZATION REVIEW PROGRAM
REQUEST FOR UTILIZATION REVIEW
19 *DEL. C.* § 2322F(j)

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION. All information and addresses must be verified as current and accurate.

1. Date of Request: _____

2. I.A.B. Number(s): _____ Date(s) of Injury: _____

3. Nature of Injury / Practice Guideline(s): _____

4. Claimant's Name: _____ Age: _____ Sex: _____
   Address: _____ Tel. No: _____
   City: _____ State: _____ Zip Code: _____

5. Employer: _____

6. Party Requesting Review: _____
   Primary Contact at Party's Office: _____
   E-Mail Address: _____
   Address: _____ Tel. No.: _____
   City: _____ State: _____ Zip Code: _____

7. Health Care Providers to be Reviewed and other Health Care Providers Impacted by Review:

   a. Health Care Provider to be Reviewed: _____
      Specialty (if applicable): _____
      Date of First Treatment: _____
      Address: _____ Tel. No.: _____
      City: _____ State: _____ Zip Code: _____

   b. Health Care Provider to be Reviewed: _____
      Specialty (if applicable): _____
      Date of First Treatment: _____
      Address: _____ Tel. No.: _____
      City: _____ State: _____ Zip Code: _____

   c. Additional Health Care Providers to be Reviewed *(list name, specialty, address, etc. on a separate sheet).*

   d. Health Care Facility(ies) Impacted (e.g., hospital, ambulatory surgery center, etc.) by this retrospective review *(list name, address, etc. on a separate sheet).*

8. Treatment to be reviewed *(specify the health care service to be reviewed and the timeframe within which the treatment was or will be rendered)*:

   _____
   _____
   _____

My signature certifies the following: (**a**) all names and addresses on this form have been verified as current and accurate; (**b**) two identical copies of associated medical material are being submitted for review; (**c**) the bill denial for the treatment subject to this review was sent within 30 days of receiving the provider's bill; *and* (**d**) all items listed in the table of contents are in each copy of the medical material.

_____ _____

NAME OF REQUESTOR SIGNATURE OF REQUESTOR

SEE INSTRUCTIONS ON BACK.

REQUIRED CONTENT, PRESENTATION AND BINDING METHOD FOR ALL MATERIALS SUBMITTED FOR UTILIZATION REVIEW

In accordance with **19 *Del. C.* § 2322F(j)** and the regulations adopted pursuant thereto, all information and medical records submitted to the Office of Workers' Compensation must represent all of the facts of this case.

INFORMATION PACKAGE · REQUIRED CONTENT:

- Completed and signed Request for Utilization Review Form.
- If applicable, a list containing (1) names, addresses, etc. of the health care facilities impacted by this review; and (2) additional health care providers under review.
- Proof of date of issuance of claim denial (so the Department of Labor can verify that Utilization Review was requested within 15 days of the date of the claim denial).

MEDICAL RECORDS PACKAGE · REQUIRED CONTENT:

Section 1. All reports, notes, etc., from provider being reviewed from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, and the time frame within which the treatment to be reviewed was or will be rendered, as submitted to the requesting party.

Section 2. All reports, notes, etc., of other treating providers from the date of injury or the one (1) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

Section 3. All diagnostic test results from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

NOTE: Do not include copies of any billing statements or comments/instructions directed to the Utilization Review panel. All material **must** be presented in identified sections; each section's content must be presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS:

- All submitted material must be presented in **TWO** (2) IDENTICAL BOUND COPIES.
- If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to: **Industrial Accident Board**
Office of Workers' Compensation
4425 N. Market St.; 3RD Floor
Wilmington, DE 19802
(302) 761-8200