

Instructions for Completing the Request for Utilization Review

Please read all pages

This form is “**fillable**”. That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the “Date of Request” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for phone number. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

Adobe Acrobat - [WC131 Request for Utilization Review.pdf]

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COLORADO DIVISION OF WORKERS' COMPENSATION
MEDICAL UTILIZATION REVIEW PROGRAM

Clear Entire Form

REQUEST FOR UTILIZATION REVIEW
(Pursuant to §8-43-501, C.R.S.)

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

**“Clear Entire Form” button
Clears all information at once**

1. Date of Request _____

2. WC Number _____ Date of Injury _____
WC Number _____ Date of Injury _____

3. Claimant's Name _____
Address _____ Tel No _____
City _____ State _____ Zip _____

Attorney's Name _____

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Tuesday
5/27/2003

**COLORADO DIVISION OF WORKERS' COMPENSATION
MEDICAL UTILIZATION REVIEW PROGRAM**

REQUEST FOR UTILIZATION REVIEW

(Pursuant to §8-43-501, C.R.S.)

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

1. Date of Request _____

2. WC Number _____ Date of Injury _____
WC Number _____ Date of Injury _____

3. Claimant's Name _____
Address _____ Tel No _____
City _____ State _____ Zip _____

Attorney's Name _____
Address _____ Tel No _____
City _____ State _____ Zip _____

4. Party Requesting Review _____
Primary Contact at Party's Office _____
Address _____ Tel No _____
City _____ State _____ Zip _____

Attorney's Name _____
Address _____ Tel No. _____
City _____ State _____ Zip _____

5. Authorized Physician to be Reviewed _____
Practice/Association Name _____
Address _____ Tel No. _____
City _____ State _____ Zip _____

6. Attach copies of all admissions and/or orders filed or entered in this case.

My signature certifies the following a) all names and addresses on this form have been verified as current and accurate; b) copies of all admissions and/or orders filed or entered in this case are attached; c) seven identical copies of associated medical material are being submitted for review; d) all items listed on the table of contents are in each copy of the medical material; and e) the initial processing fee is attached.

Print Name of Requester

Signature of Requester

COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT

SEE INSTRUCTIONS ON BACK

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

In accordance with 8-43-501, C.R.S, and Colorado Workers' Compensation Rules of Procedure, 7 CCR 1101-3, Rule 10, all information and medical records submitted to the Division for a Medical Utilization Review must represent all of the facts of this case.

INFORMATION PACKAGE - REQUIRED CONTENT

- ◆ Completed and signed Request for Utilization Review Form.
- ◆ Copies of all admissions and/or orders filed or entered in this case.
- ◆ A list containing the full names and medical degrees of all providers, including the provider under review, other treating providers, and individuals who performed or are considered as referrals, consultations, IME's and/or second opinions.
- ◆ The initial fee payment of \$1,250.00 must be included in the "Information Package", made payable to the Division of Worker's Compensation, Medical Utilization Review, and reference the claimant's name. Deposit of the fee does not constitute acceptance of the case for utilization review.

MEDICAL RECORDS PACKAGE - REQUIRED CONTENT

1. **Case Report** - prepared, signed and dated by a licensed medical professional. This report shall be dated within thirty (30) days of the date of filing with the Division. **The case report shall be limited to the following:**
 - a. Name, discipline of care and specialty of the Provider under review; date the provider first treated the claimant.
 - b. Claimant's standard demographic information (age, sex, marital status, etc.).
 - c. Claimant's employer and occupation/job title.
 - d. Date(s) of claimant's work-related injury/exposure.
 - e. Date of initial treatment, a brief chronological history of treatment to the present date, and any significant contributing factors which may have had a direct effect on the length of treatment (e.g., diabetes).
2. **Table of Contents**

Section 1.	A copy of the Employer's First Report of Injury and/or the Worker's Claim for Compensation form.
Section 2.	All reports, notes, etc., from provider being reviewed as submitted to the requesting party.
Section 3.	All reports, notes, etc., of other treating providers as submitted to the requesting party.
Section 4.	All reports resulting from referrals, consultations, IME's and second opinions as submitted to the requesting party.
Section 5.	All diagnostic test results as submitted to the requesting party.
Section 6.	All medical management reports as submitted to the requesting party.
Section 7.	All hospital/clinic records related to the injury 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 presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

- ◆ INFORMATION PACKAGE - SUBMIT ONE COPY ONLY -- staple in upper-left-hand corner.
- ◆ MEDICAL RECORDS PACKAGE - SUBMIT SEVEN (7) COPIES
 - a. All submitted material must be presented in seven (7) identical copies, two-hole punched at the top center of each page and securely fastened.
 - b. Put a blank sheet of paper on the front and back of each copy of the submitted material (any color **except** black or a very dark color).
 - c. If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to:

**Division of Workers' Compensation
Medical Utilization Review Program
633 17th St. Suite 400
Denver, CO 80202-3626
303.318.8769**