State of California
Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR - California Code of Regulations, title 8, section 9792.10.2

TO REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records where indicated.**
- **Mail or fax the application and a copy of the written decision you received that denied or modified the treatment requested by your physician to:**
  DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270
- **Mail or fax a copy of the signed application to the Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐

Employee Information		
First Name:	MI:	Last Name:
Claim Number:		Date of Injury (MM/DD/YYYY):
Date of UR Decision (MM/DD/YYYY):		Employer Name:
~~WCIS Jurisdictional Claim Number (if assigned):~~		~~EAMS Case Number (if applicable):~~
Address:		
Phone Number:		

Treating Physician Information	
Name:	Specialty:
Address:	
Phone Number:	Fax Number:

Claims Administrator Information	
Company Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	**Fax Number:**

Disputed Medical Treatment

Primary Diagnosis (Use ICD Code where practical):

~~Describe with specificity all the requested medical services, goods, or items that were denied or modified.~~
Indicate the treatment as requested on the RFA, including diagnosis and ICD code. Attach~~ed~~ additional pages if necessary.
Services/goods disputed for reasons of medical necessity:

Indicate if those services/goods are also disputed for reasons other than medical necessity

Indicate if delayed/denied because requested medical information was not received from the physician

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish. I understand this application is signed under penalty of perjury.

Original Employee Signature:	Date:

Instructions for the Application for Independent Medical Review Form

If your claims administrator denies or modifies your treating physician's request for medical services or treatment **through a process called utilization review**, you can request **at no cost** an Independent Medical Review (IMR) by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested. Please be aware that if you decide not to participate in the IMR process, you may be giving up your rights to pursue legal action against your claims administrator regarding the service or treatment you are requesting. **You can request independent medical review by signing and submitting this form with a copy of the utilization review decision and sending a copy of the ~~singed~~ signed application to your claims administrator.**

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- Sign and date the form to request IMR and to consent to obtain medical records.
- If you are seeking an expedited review and your claims administrator did not perform an expedited review on your physician's request, the form must be submitted with the physician's certification that you are facing an imminent and serious threat to your health.
- If you have or wish to designate an attorney, parent, guardian, conservator, relative, or other designee to act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Your designee may sign the application for you and submit documents on your behalf.
- An application for IMR must be filed within thirty (30) days from the mailing date of the utilization review decision letter informing you that the medical services or treatment requested by your treating physician was denied or modified.
- Mail or fax the application and a copy of the utilization review decision to:
  DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270
- Send a copy of the signed application to your Claims Administrator.

Employee Right to Provide Information

You have the right to submit, either directly or through your treating physician, information and documentation to support the requested medical treatment. Such information and documentation may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Medical information or justification that the requested medical treatment, on an urgent care or emergency basis, was medically necessary for your medical condition
- Reasonable information supporting the position that the disputed medical treatment is or was medically necessary including all information provided by the employee's treating physician or any additional material that the employee believes is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment is inapplicable or scientifically incorrect.

Determining Your Eligibility for IMR

Your application will be screened to determine if it is eligible for IMR. An application may not be eligible for review if it is incomplete, untimely filed, or if the claims administrator is disputing liability for the injury. If the application is found eligible, the Independent Medical Review Organization (IMRO) designated by the Division of Workers' Compensation will send you a letter telling you that you qualify for an IMR. The letter will include instructions as to how to submit your information and records. If the IMRO requests medical records from your treating physician, it is important that your treating physician provides the records promptly. The IMRO is required to reach a decision on your application within thirty (30) days from the date it receives all necessary documents and information. If your application is not found eligible, you will receive a decision from the Administrative Director advising you of the reason why IMR is not available in your case. Please review the IMR regulations, starting at California Code of Regulations, title 8, sections 9792.10.1, for additional requirements regarding the IMR process.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name:	

I wish to designate

Name of Individual:	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designed by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designed by the Division of Workers' Compensation to review my application.

In addition to designated the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

I am a/an:		
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)		
Representative Address/P.O. Box:		
City:	State:	Zip Code:
Representative Phone Number:		
Representative Signature:		Date: