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

All fields must be completed by the Claims Administrator. A copy of the utilization review (UR) decision that either denies, delays, or modifies a treating physician's request for authorization of medical treatment must be attached.

Type of Review (Required): ☐ Regular ☐ Expedited

Employee Information (Completion of this section is required)		
Employee First Name:	MI:	Employee Last Name:
Claim Number:		Date of Injury (MM/DD/YYYY):
Date of UR Decision (MM/DD/YYYY):		EAMS Case Number (if applicable):
WCIS Jurisdictional Claim Number (if assigned):		
Employee Address/P.O. Box:		
City:	State:	Zip Code:
Employee Phone Number:		

Medical Provider Information (Completion of this section is required)	
Provider First Name:	Provider Last Name:

Claims Administrator Information (Completion of this section is required)		
Employer Name:		
Claims Administrator Company Name:		
Claims Adjuster/Contact Name:		
Claims Administrator Address/P.O. Box:		
City:	State:	Zip Code:
Claims Administrator Phone Number:		

Requested Medical Treatment (Completion of this section is required)
Primary Diagnosis (Use ICD Code where practical):
Indicate the treatment requested. Attached additional pages if necessary.

I request an independent medical review of the above-described requested medical treatment.

Employee/Applicant Signature:	Date:

Consent to Obtain Medical Records

I am asking for an independent medical review to make a decision about the requested medical treatment that was delayed, denied, or modified by my claims administrator. I allow my health care providers and claims administrator to furnish 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:

Filing Information

Mail or fax your application and any attachments to: DWC-IMR, c/o Maximus Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009
FAX: (916) 364-8134

Instructions for the Application for Independent Medical Review Form
Instructions for the Employee

If your claims administrator denies, delays, or modifies your treating physician's request for medical services or treatment, you can request an Independent Medical Review (IMR) by a physician who is not connected to your claims administrator. The specialty of the reviewing physician will be matched to the specialty of your treating physician or the specialty most knowledgeable about the disputed medical services or treatment. The request must be made on this form. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested. You pay no costs for an IMR. 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.

How to Apply

All of the information on the form, except for your signatures, should already be filled in by your claims administrator when you receive the form. Review the form to make sure that all the information provided by your claims administrator is correct. If you believe that any of the information on the form is incorrect, please submit a separate sheet that provides the correct information. Sign and date where indicated to request an independent medical review of described treatment request. Also, please review the consent to obtain medical records, then sign and date where indicated to indicate your consent. 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, please 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, delayed, or modified. Please include a copy of the utilization review decision with your application.

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 initially screened to determine if it is eligible for IMR. If the Application is found eligible, you will be sent written notification of the contact information of the Independent Medical Review Organization (IMRO). You must then send to the IMRO, as instructed, the relevant medical records as defined by California Code of Regulations, title 8, section 9792.10.5. Please review California Code of Regulations, title 8, sections 9792.10.1, et seq. for additional requirements regarding the IMR process. Note that claims administrators are responsible for the costs of IMR. If the IMRO requests medical records from your treating physician, it is important that your treating physician provides the records promptly.

The IMRO designated by the Division of Workers' Compensation will review your application and 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 your application for a regular, non-expedited review is determined to be eligible for IMR, the IMRO is required to reach a decision on your application within thirty (30) days from the date they receive all necessary documents and information.

Do Not File this page with your request for IMR

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: