Reset Form | Print Form

State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Medical Review

(All fields must be completed by the Claims Administrator)

Type of Review *(Required)*
☐ Regular
☐ Expedited

Claims Number *(Required)* | Date of Injury *(Required)* | Date of UR Decision *(Required)* | WCIS Claim Number *(Required)* | EAMS No (if applicable)

Injured worker Information (Completion of this section is required)

Injured Worker First Name | MI | Injured Worker Last Name

Injured Worker Street Address/PO Box | Injured WorkerCity | State | Zip Code

Medical provider information (Completion of this section is required)

Provider First Name | Provider Last Name

Employer and Claims Administrator Information (Completion of this section is required)

Employer Name (Please leave blank spaces between numbers, names or words)

Claims Administrator Company Name (Please leave blank spaces between numbers, names or words)

Claims Examiner Name

Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Claims Administrator City | State | Zip Code

Primary Diagnosis (Use ICD Code where practical) | Indicate the treatment requested, attach additional pages if necessary

Is the claims administrator disputing liability for the requested medical treatment besides the question of medical necessity?

☐ Yes ☐ No If yes, indicate why liability is being disputed

Consent to obtain medical records

I am asking for an independent medical review (IMR) 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 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 of the Division of Workers' Compensation 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.

Date: MM/DD/YYYY | Employee's Signature

File this Application by mail by sending the form to: *DWC-IMR, c/o MAXIMUS Federal Services, Inc.*
625 Coolidge Drive, Suite 100, Folsom, CA 95630

You may also file this form by faxing the document to: Fax (916) 364-8134

IMR Application Instructions

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 signature, 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. Review the consent to obtain medical records, then sign and date the form where indicated at the bottom. If you are seeking an expedited review, 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 designated a parent, guardian, conservator, relative, or other designee to act on your behalf in filing this application, they may sign for you. An application for IMR must be filed within thirty (30) days from the day you receive the utilization review decision letter informing you that the medical services or treatment requested by your treating physician was denied, delayed, or modified.

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

The 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, as instructed, the relevant medical records as defined by California Code of Regulations, title 8, section 9792.10.5 to the IMRO. 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