

State of California, Division of Workers' Compensation  
**APPLICATION FOR INDEPENDENT MEDICAL REVIEW**  
 DWC Form IMR

**TO REQUEST INDEPENDENT MEDICAL REVIEW:**

1. Sign and date this application and consent to obtain medical records.
2. Mail or fax the application and a copy of the written decision you received that denied or modified the medical 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**
3. Mail or fax a copy of the signed application to your Claims Administrator.

|  |                                   |  |
|--|-----------------------------------|--|
| Type of Utilization Review: <input type="checkbox"/> Regular <input type="checkbox"/> Expedited  |                                   | Modification after Appeal <input type="checkbox"/> |
| <b>Employee Name (First, MI, Last):</b>  |                                   |  |
| Address:   |                                   |  |
| Phone Number:  | Employer Name:                    |  |
| Claim Number:  | Date of Injury (MM/DD/YYYY):      |  |
| WCIS Jurisdictional Claim Number (if assigned):  | EAMS Case Number (if applicable): |  |
| Employee Attorney (if known):  |                                   |  |
| Address:   |                                   |  |
| Phone Number:  | Fax Number:                       |  |
| <b>Requesting Physician Name (First, MI, Last):</b>  |                                   |  |
| Practice Name:   | Specialty:                        |  |
| Address:   |                                   |  |
| Phone Number:  | Fax Number:                       |  |
| <b>Claims Administrator Name:</b>  |                                   |  |
| Adjuster/Contact Name:   |                                   |  |
| Address:   |                                   |  |
| Phone Number:  | Fax Number:                       |  |
| <b>Disputed Medical Treatment (complete below section)</b>   |                                   |  |
| Primary Diagnosis (Use ICD Code where practical):  |                                   |  |
| Date of Utilization Review Determination Letter:   |                                   |  |
| Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:  |                                   |  |
| List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.   |                                   |  |
| 1.   |                                   |  |
| 2.   |                                   |  |
| 3.   |                                   |  |
| 4.   |                                   |  |
| <b>Request for Review and Consent to Obtain Medical Records</b>  |                                   |  |
| 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, unless infection with or exposure to HIV is claimed as my work injury. 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:  |

## INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request 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.

**IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.**

**You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the 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.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did **not** perform an expedited or rushed review on your physician's request, this application **must** be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- 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**

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

### **Your Right to Provide Information**

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

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at [www.dwc.ca.gov](http://www.dwc.ca.gov).

**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 (Print): |  |
|------------------------|--|

I wish to designate

|                             |  |
|-----------------------------|--|
| Name of Individual (Print): |  |
|-----------------------------|--|

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 designated 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 designated by the Division of Workers' Compensation to review my application.

In addition to designating 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.

|   |             |           |  |
|---|-------------|-----------|--|
| Name:   |             |           |  |
| I am a/an:  |             |           |  |
| (Professional status or relationship to the Employee, e.g., attorney, relative, etc.) |             |           |  |
| Address:  |             |           |  |
| City:   | State:      | Zip Code: |  |
| Phone Number:   | Fax Number: |           |  |
| State Bar Number (if applicable):   |             |           |  |
|   |             |           |  |
| Representative Signature:   |             | Date:     |  |