

CLAIM # _____
CARRIER'S CLAIM # _____

REQUIRED MEDICAL EXAMINATION NOTICE OR REQUEST FOR ORDER

Examen Médico Requerido o Orden Para Pedir el Examen

Part I: General Information *Información General*

Requestor *Solicitante* Insurance Carrier *compañía de seguros* Texas Department of Insurance, Division of Workers' Compensation

1. Employee's Name <i>Nombre del trabajador</i>	8. Insurance Carrier's Name <i>Nombre de la compañía de seguros</i>
2. Mailing Address (Street or P.O. Box) <i>(calle o apartado postal)</i>	9. Mailing Address (Street or P.O. Box) <i>(calle o apartado postal)</i>
City <i>Ciudad</i> State <i>Estado</i> Zip Code <i>Código Postal</i>	City <i>Ciudad</i> State <i>Estado</i> Zip Code <i>Código Postal</i>
3. Employee's Social Security Number <i>Número de seguro social</i>	10. Employer's Name <i>Nombre del empresario</i>
4. Employee's Telephone Number <i>Número de teléfono</i>	11. Business Location (Street or P.O. Box) <i>(calle o apartado postal)</i>
5. Date of Injury <i>Fecha de lesión</i>	City <i>Ciudad</i> State <i>Estado</i> Zip <i>Código Postal</i>
6. Attorney's Name (If applicable) <i>Nombre del Abogado</i>	12. Type of examination requested by the insurance carrier <i>Que clase de examen esta solicitando la compañía de seguros:</i>
7. Mailing Address (Street or P.O. Box) <i>(calle o apartado postal)</i>	<input type="checkbox"/> One every 180 days <i>Uno cada 180 días</i>
City <i>Ciudad</i> State <i>Estado</i> Zip Code <i>Código Postal</i>	<input type="checkbox"/> Additional examination before expiration of 180 day period Examen adicional antes de que termine el periodo de los 180 días <i>(If additional RME, Part IV must be completed <i>Si más exámenes médicos son requeridos la IV parte debe llenarse</i>)</i>
Date request for RME sent to employee and employee's representative (if any).	<input type="checkbox"/> Examination to evaluate MMI and/or permanent impairment after a Designated Doctor's examination conducted on _____

Part II: Examination Information *Información Acerca de los Exámenes*

13. Examining Doctor's Name <i>Nombre del médico examinante</i>	19. Previous medical examinations at carrier's request: <input type="checkbox"/> None <i>Examinaciones previas medicas solicitadas por Ninguno la compañía de seguros</i>
14. Mailing Address (Street or P.O. Box) <i>(calle o apartado postal)</i>	Date of Examination Type of Exam Name of doctor <i>Fecha del examen Typo del examen Nombre del médico</i>
City <i>Ciudad</i> State <i>Estado</i> Zip Code <i>Código Postal</i>	_____ _____ _____
15. Specialty <i>Especialidad</i>	_____ _____ _____
16. Doctor's Telephone Number <i>Número de teléfono del médico</i>	20. Is the requested doctor the same doctor as the previous examinations at the insurance carrier's request? <i>Es el médico solicitado el mismo médico de las examinaciones anteriores solicitadas por la compañía de seguros?</i>
17. Doctor's License Number <i>Número de licencia del médico</i>	Yes <i>Si</i> <input type="checkbox"/> No <input type="checkbox"/>
18. Date and time of appointment <i>Día y hora de la cita :</i>	If no, please explain the reason for the request for a different doctor. <i>Si no, por favor explique la razón para escoger un medico diferente.</i>
21. Purpose of Examination <i>El objeto de la examinación:</i>	



Part III: Carrier's Attempts for Agreement or Non-Agreement by Injured Employee

Parte III: Intento de La compañía de seguros para un acuerdo o no con el trabajador lesionado

22. Describe carrier's attempts to obtain agreement of the injured employee (i.e. telephone call, letter, and dates performed, etc.) and injured employee's response. Describa el intento de la compañía de seguros para obtener un acuerdo con el trabajador lesionado (ejemplo, llamada por teléfono, una carta etc..) y la respuesta del trabajador lesionado.

Note: Does not apply under Rule 130.5

**Part IV: Request for Additional Required Medical Examination
Solicitud Requeridá para un Exámen Médico Adicional**

(Must be completed by the insurance carrier ONLY if this is a request or notification of a required medical examination before the expiration of 180 days from the previous examination. Esta parte debe ser llenada por la compañía de seguros unicamente si es un pedido o notificación de un exámen médico requerido antes de los 180 dias del ultimo exámen.)

23. Reason for examination before the expiration of 180 days. Razon por examinación antes de expiración de 180 dias.[Rule/Reglamento 126.5(d)]. Need to determine if:

- a. Change in condition
Cambio en condición
- b. Change in diagnosis
Cambio en diagnóstico
- c. Extent of injury changed
Gravedad de su lesión
- d. Producing cause
Causa productora
- e. Disability, new information
Incapacidad, nueva infomación
- f. Necessity of surgery Necesidad de cirugia

24. Explanation of good cause for an additional examination prior to the expiration of 180 days. Una explicación de causa justa para hacer un exámen adicional antes de que se terminen los 180 dias.

Note: Limits in 126.5 (b) (3) not applicable.

**CARRIER CERTIFICATION
Certificación de la Compañía de Seguros**

I hereby certify that this request is complete and accurate and understand that making a misrepresentation about a workers compensation claim is a crime that can result in fines and/or imprisonment, and: Yo certifico que esta solicitud es correcta y esta completa y entiendo que el falsificar un reclamo de compensacion es un crimen que puede resultar en multa y/o carcel:

- I have attempted to obtain an agreement of the injured employee for the examination. He tratado de obtener un acuerdo con el trabajador lesionado para el exámen. (Note: Does not apply under Rule 130.5)
- I will schedule an examination within 30 days of receiving this order and give at least 10 days notice to the injured employee. Fijará una cita para hacer el exámen lo más rápido posible y le avisará al trabajador lesionado por lo menos en 10 dias de anticipación.
- The carrier will pay reasonable expenses incident to the examination of the injured employee La compañía de seguros pagará los gastos razonables relacionado con el exámen del trabajador.

Signature of the Adjuster Firma del ajustador

Date Fecha

Adjuster's License Number

Telephone

Printed Name of Adjuster Nombre del ajustador

**DIVISION ORDER
Orden de la División**

Request Approved Solicitud Aprobada. The injured employee is ordered to submit to an examination by the doctor listed in this order. If additional examination, the Division finds good cause for the requested examination. El trabajador lesionado debe presentarse al examen con el médico nombrado en esta orden. Sí más exámenes la División encuentra motivo suficiente para la solicitud del examen.

If an employee fails or refuses to appear for the examination without good cause the carrier may suspend temporary income benefits and the employee may be assessed an administrative violation. The employee must by the day of the examination either submit to the examination or contact the doctor's office to reschedule the examination to occur no later than the later of the seventh day after the original appointment or an extended date as granted by the local Division office. If the carrier suspends temporary income benefits and the employee submits to the required medical examination, the carrier must reinstate temporary income benefits as of the date the employee submitted to the examination.

Si un trabajador no se presenta o se reusa a un examen sin tener una buena causa, la compañía de seguros podra suspender los beneficios de ingresos temporarios y al trabajador se le podra hacer una multa administrativa. El trabajador debera, en el día del examen, presentarse al examen o cambiar la fecha del examen no mas tarde de siete días despues de la fecha original del examen o la cita mas reciente que el doctor le pueda dar. Si la compañía de seguros le suspende los beneficios de ingresos temporarios y el trabajador se presenta al examen medico requerido, la compañía de seguros le debera restablecer los beneficios de ingresos temporarios desde la fecha en que el trabajador se presento al examen.

Request Denied Solicitud Negada/Reason Razon: _____

Authorized Signature Firma autorizada

Date of Order Fecha de la orden

Telephone Teléfono



Additional Information for Insurance Carriers
DWC FORM-22
(Required Medical Examination Notice or Request for Order)

Where should the form be filed?

The form should be filed with the field office handling the claim and include the CLAIM Number, if known. Filing the form in the Central Office, a different field office or without the CLAIM Number will delay processing of the request.

Which name and address for the employer should be listed in Box 10 and 11?

Always use the name and address of the employer that is listed on the insurance policy to ensure that the form can be properly linked to the correct employer and carrier. The use of a different name or address can create problems which will delay the processing of the request.

Which parts of the form should be completed for the different types of examinations indicated in Box 12?

Parts I, II, III, and the carrier certification should be completed for every required medical examination (RME). If the form is submitted to notify the commission of an agreed RME, be sure to include the date and time of the appointment in Box 18 of Part II. If the RME is an additional RME prior to the expiration of 180 days, Part IV must also be completed.

How should the agreement section (Part III) be used?

The insurance carrier is required by Rule 126.5(d) to attempt to obtain the agreement of the employee for an examination by a doctor of his/her choice. In block 22 you should describe and date attempts to get an agreement and the response from the injured employee. Block 18 should be completed if agreement is reached.

What types of information should be included in Box 24 for additional RMEs?

Box 24 should include the specific and detailed explanation of why there is good cause for an additional RME within 180 days. This may include the information regarding what caused the need for the additional RME and what items need to be addressed.

When should the carrier's certification be completed?

The carrier's certification should be completed on all requests for orders or notifications of agreed RMEs.

