EXAMPLE FORM DWC-49

This form is used by the proposing doctor to initiate the "Prospective Review of Medical Care Not Requiring Preauthorization" process. This example is intended to be printed as a guide to what information is required on the form. It is an example only. Each DWC -49 should be case specific.

Fill out the form completely.

Send To:
DWC Field Office Handling Claim, if known, or
DWC
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

DWC # 04-123456

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

REQUEST FOR PROSPECTIVE REVIEW OF MEDICAL CARE NOT REQUIRING PREAUTHORIZATION

1. Employee's Name (Last, First, M.I.) DOE, JOHN Q	7. Treating Doctor's Name (Last, First, M.I.) and Title PARKER, RICK M. MD
2. Employee's Mailing Address (Street or P.O. Box) 123 MAIN ST	8. Treating Doctor's Mailing Address 400 COLLEGE AVE
City AUSTIN / State TX / Zip Code 78704	City AUSTIN / State TX / Zip Code 78700
3. Employee's Telephone # 512-555-1111 / Fax # NONE	9. Treating Dr's Telephone # 512-945-1000 / Fax # 512-945-1001
4. Employee's Social Security Number 123-45-6789	10. Insurance Carrier's Name TX STATE INS / 10a. Insurance Carrier Claim # TX 1000053
5. Date of Injury 1-15-04	11. Adjuster's Name BOB TAYLOR / Adjuster's Telephone # 512-650-0000
6. Name of Representative (if any) NONE	12. Signature of Employee or Representative *If injured worker has an attorney, have the attorney sign here.*

Get all necessary signatures.

This section to be completed by the doctor proposing the medical care in question:

13. Proposing Doctor's Name, License Number, License Type SUSAN BAXTER D1234 PHYSICIAN	15. Telephone # 512-445-5000 / Fax # 512-445-5001
14. Mailing Address 500 CENTER LANE, AUSTIN, TX 78888	16. Email Address DRSUE@BAXTER.COM

Pay close attention to boxes 17, 18, 19 and 20 – be specific.

Include treatment codes (box 17).

Include diagnosis codes (box 18).

Don't attach medical records- summarize the proposed care and details.

17. Specific medical care, requested number of sessions, and duration of care being proposed to treat the employee's current medical condition (include treatment codes):

10 MG FLEXERIL, THREE TIMES DAILY FOR ONE MONTH (QUANTITY 90)
ONE OFFICE VISIT - TREATMENT CODE: 99213

Note: During 1st three months after injury, doctor may request treatment for a period of up to ONE month.
After 1st three months, doctor may request treatment for a period of no longer than THREE months in duration.

18. Thorough explanation of the medical necessity of the care being proposed (include diagnosis codes):

INJURED WORKER IS RECOVERING FROM INJURY TO LOW BACK. FLEXERIL IS NEEDED TO HELP WITH MUSCLE RELAXATION TO REDUCE PAIN, PROMOTE RECOVERY, AND PHYSICAL THERAPY.
DIAGNOSIS CODE: 728.85

19. Basis for the medical opinion that the compensable injury is a producing cause of the current medical condition that is the subject of the proposed care:

MEDICAL RECORDS SUPPORT THAT THE INJURED WORKER'S LOWER BACK WAS INJURED WHEN HE FELL AT WORK ON 1-15-04.

20. Factually substantiated rationale that establishes the carrier's intent to deny reimbursement for the proposed care:

IN CONVERSATION WITH ADJUSTER, BOBY TAYLOR, ON 12/6/04, HE INFORMED ME THAT HE WOULD NOT APPROVE PAYMENT FOR FLEXERIL.

21. Proposing Doctor's Signature *Susan Baxter, MD*	22. Treating Doctor's Signature (indicating concurrence with the proposed care, if not the Proposing Doctor) *Dr. Rick M. Parker MD*

File the form with tthe local field office handling the claim.