Send To: TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
Field Office Handling Claim

CLAIM # _____

Carrier's Claim #_____

REQUEST FOR A BENEFIT REVIEW CONFERENCE

I hereby request a Benefit Review Conference be scheduled in _____
(location)

The Benefit Review Conference will be conducted at a location no more than 75 miles from the claimant's residence at the time of the injury, unless the Division determines that good cause exists for the selection of a different location.

1. Employee's Name (Last, First M I)
2. Social Security Number
3. Date of Injury
4. Insurance Carrier's Name
5. Employer's Business Name

Check applicable box(es):

☐ 1. Carrier selected doctor has released injured employee to return to work (medical report attached).

☐ 2. Disputing the findings of the designated doctor on Maximum Medical Improvement or impairment.

☐ 3. Carrier selected doctor has certified that the injured employee has reached Maximum Medical Improvement (medical report has not attached). The injured employee's treating doctor, Dr. _____ , disagrees with the certification or has not responded, and a request for a designated doctor has been previously made to the Division or a request is attached.

☐ 4. Requested as provided in Rule 130.4, Titled *Presumption That Maximum Medical Improvement Has Been Reached*, based on an apparent lack of medical improvement or abandonment of medical treatment. (A request for a required medical examination or a request for a designated doctor must be attached if the carrier alleges the presumption of Maximum Medical Improvement or if the lack of medical improvement is identified.)

☐ 5. Contesting the determination of entitlement to or amount of Supplemental Income Benefits or whether the injured employee's underemployment is a direct result of the impairment.

☐ 6. Employer contesting compensability after the insurance carrier has accepted liability.

☐ 7. Other (Explain) _____

Briefly describe each unresolved issue and discuss resolution attempts. _____

_____

_____

(Additional pages may be attached)

☐ 8. An expedited Benefit Review Conference.

☐ *9. Special accommodations are needed (Does not speak English, has a physical, mental or developmental handicap)* please describe:

Requested By: ☐ **Employee** ☐ **Carrier** ☐ **Employer** ☐ **Subclaimant** ☐ **Beneficiary**
☐ **Attorney for** _____

By my signature below, I certify that a good faith effort has been made to resolve the issues identified above.

Requester's Signature _____

Requester's Typed or Printed Name _____ Phone No. ( )

Requester's Mailing Address _____

Date of Request _____

cc: Carrier or Employee/Representative

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.

NOTA: Usted tiene derecho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas excepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437.

DWC FORM - 45
(Request for a Benefit Review Conference)

A party to a claim is entitled to file a **Request for a Benefit Review Conference** (DWC FORM-45) with the Texas Department of Insurance, Division Workers' Compensation in order to mediate and resolve disputed issues. An unrepresented claimant may request a benefit review conference by contacting the Texas Department of Insurance, Division of Workers' Compensation in any manner and is not required to file this form. The Texas Department of Insurance, Division of Workers' Compensation will schedule the conference to be held within 40 days of the filing date of the request, or within 20 days if an expedited conference is requested and warranted. The conference will be conducted at a site no more than 75 miles from the claimant's residence, at the time of the injury, unless the Division determines that good cause exists for the selection of a different location.

This form is color coded blue to expedite handling. The DWC FORM-45 is considered filed when received by the Texas Department of Insurance, Division of Workers' Compensation or when personally delivered to the Texas Department of Insurance, Division of Workers' Compensation. **The form should be filed with the Field Office handling the claim.** Failure to file the form with the appropriate field office may delay processing.

[Texas Labor Code, Sec. 410.023-.025/410.028 Request for Benefit Review Conference, Sec. 410.021; Rule 141.1]