Send to: May be Faxed to: (512) 804-4714

The Texas Department of Insurance
Division of Workers' Compensation
Medical Review MS-41
7551 Metro Center Drive, Ste 100
Austin, Texas 78744-1609

CLAIM#: ______________________

Carrier Claim#: ______________________

NON-ADL DOCTOR REQUEST FOR CASE-BY-CASE EXCEPTION

GENERAL CLAIM AND REQUESTOR IDENTIFICATION INFORMATION:

1. Employee's Name (Last, First) and Address		1a. Date of Injury	1b. Date of Birth
		1c. Employee's Social Security #	1d. Employee's Telephone # (_____) _____ -_______
City State ZIP		2. Employer's Name and Address	
3. Representative's Name			
3a. Telephone # (_____) _____ -______ ext ____	3b. Facsimile # (_____) _____ -_______	City State ZIP	
☐ Treating doctor requesting referral to Non-ADL doctor		4. Insurance Carrier	
☐ Non-ADL doctor requesting exception to requirement to be on the ADL to allow access to health care		By agreeing to provide treatment, the Non-ADL doctor agrees to bill in accordance with the Division's 2002 Medical Fee Guidelines.	
5. Treating Doctor's Full Name (Last, First) and Address		6. Non-ADL Doctor's Name (Last, First) and Address	
City State ZIP		City State ZIP	
5a. Treating Doctor's E-Mail Address		6a. Non-ADL Doctor's E-Mail Address	
5b. Treating Doctor's License #	5f. Treating Doctor's Specialty	6b. Non-ADL Doctor's License #	6f. Non-ADL Doctor's Specialty
5c. Social Security #	5g. Date of Birth	6c. Social Security #	6g. Date of Birth
5d. License Jurisdiction	5h. License Type	6d. License Jurisdiction	6h. License Type
5e. Telephone # (_____) _____ -_______	5i. Facsimile # (_____) _____ -_______	6e. Telephone # (_____) _____ -_______	6i. Facsimile # (_____) _____ -_______

Signature of Requesting Doctor ____

II REASON FOR EXCEPTION REQUEST:

Description of Reason for Exception Request. Include grounds that establish good cause for exception and justify length of exception requested. **This form is not for use by IRO doctors.** Those doctors should contact the Division for additional information.

Exception Requested Through Date: _____/________/_______

DIVISION ORDER

☐ Exception Approved. Pursuant to Rule 180.23(b), an exception is hereby granted to the training and registration requirements to allow access to health care or evaluations for the above stated employee. The insurance company shall review and pay all reasonable and necessary medical care as required by T.L.C. Section 408.021.

☐ Exception granted from ______________________ to ______________________

NOTE: *Exception begin date cannot be prior to DWC's stamped received date. Any services provided prior to request for exception will not be covered.*

☐ Exception Denied. Reason for denial:

Authorized DWC Employee's Signature ____

Title Telephone Number Date

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