

PETITION FOR REVIEW OF UTILIZATION REVIEW DETERMINATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER -	MM DD YYYY
If the insurer/employer, employee or provider disagrees with the cemployee or provider may file this petition to request that a Work	determination rendered against it by the URO, the insurer/employer, ers' Compensation Judge review the URO's determination.
EMPLOYEE	EMPLOYER
First name	Name
Last name	Address
Date of birth	Address
Address	City/Town State ZIP
Address	County
City/Town State ZIP	Telephone FEIN
County	VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)
Telephone	Name
	Address
Utilization Review Number:	Address
URO name	City/Town State ZIP
Address	County
Address	Telephone FEIN
City/Town State ZIP	Insurer/TPA claim #
This request is filed by or on behalf of Employee Insur	rer/Employer Health Care Provider
ATTORNEY FOR INSURER/EMPLOYEE (if known)	ATTORNEY FOR INSURER/EMPLOYER (if known)
Name	Name
Firm name	Firm name
Address	Address
Address	Address
City/Town State ZIP	City/TownState ZIP
Telephone PA Attorney ID number	Telephone PA Attorney ID number

I hereby request that this petition be assigned to a Workers' Compensation Judge for a hearing to determine the reasonableness or necessity of the treatment provided by or prescribed by the health care provider below:

PROVIDER UNDER REVIEW	ATTORNEY FOR PROVIDER (if known)
First name	Name
Last name	Firm name
Address	Address
Address	Address
City/Town State ZIP	City/TownState ZIP Telephone PA Attorney ID number
	' can be obtained from the UR Request form. CEDURE CODES TO IDENTIFY TREATMENT TO BE REVIEWED)
Date(s) of treatment to be reviewed: MM DD YYYYY	
I hereby certify that on this day I have mailed a copy of this p provider whose treatment is under review.	etition to all parties and their attorneys, if known, including the
Requesting Party or Representative's signature	Requesting Party or Representative's name (typed/printed)
Date MM DD - YYYY	

NOTICE: Petition will be returned if not signed and dated. Do not attach any documents to this petition. The Workers' Compensation Office of Adjudication will destroy all attachments and NOT forward them to the Workers' Compensation Judge and NOT return them to you.

NOTE: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N 7th Street, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A proof of service must be attached. A proof of service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services 717.772.3702 Claims Information Services toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447 **Hearing Impaired** toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991 **Email** ra-li-bwc-helpline@pa.gov

