

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr., 1B

Nashville, Tennessee 37243-1002

Website: www.tn.gov/labor-wfd/wcomp.html



If you disagree with the denial of your medical treatment by the Utilization Review Agent, you have the right to appeal the decision. Either you, your attorney or your treating physician can ask the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development to review the facts of your case and to issue an opinion. That review will be performed at no cost to you.

If you wish to seek such a review, you must:

1. Complete the remainder of the attached form and submit the completed form that is entitled "Notice of Appeal Rights for a Utilization Review Denial;" and
2. Provide a copy of the Utilization Review Decision and Peer Reviewer's Report; and
3. Provide a copy of all medical records over the past twelve (12) months pertaining to the workers' compensation injury, including office visits, diagnostic reports, operative notes, physical therapy notes, and hospital visits; and
4. Provide a copy of any medical release that you have signed for the authorized treating physician or a signed "Medical Waiver and Consent" Form C-31; and
5. Submit to the TDLWD, Workers' Compensation Division either by fax to (615) 253-5265, by email to wc.info@tn.gov, or by mail at 220 French Landing Drive, 1B, Nashville, TN 37243-1002 within thirty (30) calendar days of the date of receipt of the Utilization Review Report.

If the completed form is not received by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development within those thirty (30) calendar days you may lose your right to appeal to the Medical Director.

If you have any questions or need assistance in completing this form, call 1-800-332-2667.

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NOTICE OF APPEAL RIGHTS FOR A UTILIZATION REVIEW DENIAL

An employee, authorized treating physician or an attorney representing an employee may appeal a Utilization Review (UR) Agent's denial of a recommended medical treatment or procedure. The appeal must be submitted, using this form, to the Workers' Compensation Division within 30 days of the date of receipt of the Utilization Review Report.

For assistance in completing this form call 1-800-332-2667.

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS SECTION MUST BE COMPLETED BY THE UR AGENT. IT MUST ACCOMPANY THE UTILIZATION REVIEW REPORT AND BE GIVEN TO ALL PARTIES IN ALL DENIALS.

<p>State File No.: _____</p> <p>Claimant Name: _____</p> <p>Injury Date: _____</p> <p>SSN: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p>	<p>UR Agent: _____</p> <p>UR State Registration No.: _____</p> <p>Date of UR Report: _____</p>
CARRIER	
<p>Carrier Name: _____</p> <p>Adjuster Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p> <p>Claim No.: _____</p>	<p style="text-align: center;">AUTHORIZED TREATING PHYSICIAN</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p> <p style="text-align: center;">EMPLOYER/CARRIER ATTORNEY (if applicable)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p>

THIS SECTION IS TO BE COMPLETED ONLY IF THE EMPLOYEE WISHES TO APPEAL THE DENIAL. IT MAY BE COMPLETED BY THE EMPLOYEE, THE AUTHORIZED TREATING PHYSICIAN OR THE EMPLOYEE'S ATTORNEY.

<p>CLAIMANT</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p>	<p>CLAIMANT ATTORNEY (if applicable)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p>
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Printed Name of Person Submitting Request: _____

Failing to provide all of the information requested on this form may cause a delay in processing it. The completed form, along with a copy of the UR Report and all relevant medical records, must be submitted to the Division either by fax: (615) 253-5265, by email to: wc.info@tn.gov, or by mail to: TDLWD, Workers' Compensation Division, ATTN: Medical Director, 220 French Landing Drive, 1B, Nashville, TN 37243-1002