GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 9-E – UTILIZATION REVIEW OR HEARING REQUEST FORM

This form is to be completed by Claimants requesting a Hearing before the Chief Risk Officer (CRO), when a Claimant disagrees: (1) with the Program's denial of authorization for a prescribed medical treatment or supply; or (2) with the treatment prescribed by a healthcare provider that is authorized by the Program.

DEADLINE: This request must be received by the Office of Risk Management (ORM) within **thirty (30)** calendar days from: (1) the date on the Notice denying the service; or (2) where Claimant disagrees with a prescribed treatment, the date the medical care, supply, or service was prescribed. If the calendar-day filing deadline falls on a Saturday, Sunday, or a legal holiday, the deadline is extended to the next business day ORM is open.

If you file a request after the deadline, your request may be denied. You are responsible for making sure your request is timely filed. No one is authorized to give you different instructions about the deadline. Please submit with this form a copy of the Notice or Medical Record documenting the prescribed medical care, supply, or service disputed and any necessary attachments. This request, excluding supporting documentation, shall not exceed 1- page.

I. General Information:			
Claimant Name:		**Claim Number:**	
Street Address:	**City:**	**State:**	**Zip:**
E-mail:	**Phone:**	**Fax:**	
Provider/Physician Name:		**Date of Notice or Care, Supply, or Service Prescribed:**	
Describe the Medical Care, Service, or Supply you are seeking Utilization Review or a Hearing on:			

II. Nature of Request: Choose only ONE (1) of the following.

☐ **I am requesting UTILIZATION REVIEW.** If you are requesting a Utilization Review, you **MAY** complete Section III.

☐ **I am requesting a HEARING.** If you are requesting a hearing before the CRO, you **MUST** complete Section III.

III. Reason for Disagreement with Denial of Authorization or Prescribed Treatment.
(1) Why do you consider the denial of authorization or the prescribed treatment to be incorrect? *(You may use additional paper if necessary).*
(2) List detailed facts supporting the reason(s) for why the denial of authorization or the prescribed treatment is incorrect? *(You may use additional paper if necessary).*
(3) What do you want the Chief Risk Officer to do? *(You may use additional paper if necessary).*

Return this form and supporting documents to **ORM by electronic mail, fax, or regular mail** to the address:

Office of Risk Management – PSWCP
One Judiciary Square, 441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001

Email: wc.claims@dc.gov
Fax: (202) 535-1130