



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
 7551 Metro Center Drive, Suite 100 • MS-94  
 Austin, TX 78744-1645  
 (800) 252-7031 phone • (512) 804-4378 fax

Si desea hablar con alguien sobre este formulario o acerca de su reclamación, llame al ajustador de su aseguradora al número de teléfono que aparece en la Casilla 15 de la Sección III.

Complete if known:  
 DWC Claim #  
 Carrier Claim #

**Required Medical Examination (RME) - Request for Agreement / Request for Order**

**I. EMPLOYEE/EMPLOYEE'S ATTORNEY INFORMATION**

1. Employee's Name (First, Middle, Last)		2. Employee's Social Security Number	
3. Employee's Address (Street or PO Box, City State Zip)			
4. Employee's Telephone Number ( )	5. Alternate Telephone Number (if available) ( )	6. Date of Injury (mm/dd/yyyy)	
7. Attorney/Representative's Name (if applicable)		8. Attorney/Representative's Address (Street or PO Box, City State Zip)	

**II. EMPLOYER INFORMATION (at the time of the injury)**

9. Employer's Name	10. Employer's Address (Street or PO Box, City State Zip)
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**III. INSURANCE CARRIER INFORMATION**

11. Insurance Carrier's Name	12. Insurance Carrier's Address (Street or PO Box, City State Zip)	13. Adjuster's Name	
14. Adjuster's E-mail	15. Adjuster's Telephone Number ( ) ext.	16. Adjuster's Fax Number ( )	17. Adjuster's License Number

**REQUEST FOR RME: EVALUATION OF DESIGNATED DOCTOR DETERMINATION (Complete Sections IV, V and VI)**

**IV. EXAMINATION INFORMATION**

18. Examining RME Doctor's Name	19. RME Doctor's Mailing Address (Street or PO Box, City State Zip)	20. RME Doctor's License Number
21. RME Doctor's Telephone Number ( )	22. Examination Location (Street, City State Zip)	23. Date and Time of Appointment
24. Does the claim involve medical benefits provided through a Certified Health Care Network? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the network.		
25. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the health care plan.		
26. Are the employee's address (Box 3) and the examination location (Box 22) more than 75 miles apart? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain why the employee is being required to travel more than 75 miles for the examination.		

**V. PURPOSE OF EXAMINATION**

27. Designated Doctor's Name	28. Date of Designated Doctor examination
29. Issues in the Designated Doctor's report to be addressed in requested RME. Check all that apply: <input type="checkbox"/> Maximum Medical Improvement <input type="checkbox"/> Impairment Rating <input type="checkbox"/> Extent of compensable injury <input type="checkbox"/> Whether disability is a direct result of work-related injury <input type="checkbox"/> Ability to return to work (DWC Form-073) <input type="checkbox"/> Ability to return to work after the second anniversary of entitlement to supplemental income benefits (Texas Labor Code §408.151) <input type="checkbox"/> Other (explain)	

**VI. INSURANCE CARRIER CERTIFICATION**

30. I hereby certify the following: <ul style="list-style-type: none"> <li>This request is complete and accurate.</li> <li>The insurance carrier will pay reasonable expenses incident to the examination of the injured employee.</li> <li>The selected doctor does not have a disqualifying association.</li> <li>If the claim involves medical benefits provided through a political subdivision pursuant to §504.053(b) of the Texas Labor Code, this RME is necessary to resolve an issue relating to the entitlement to or amount of income benefits as required by §504.053(c)(1) of the Texas Labor Code.</li> <li>I am authorized to act on behalf of the insurance carrier.</li> </ul> I understand that misrepresenting a workers' compensation claim may result in enforcement action including administrative penalties and fines.	
31. Signature of Adjuster or Authorized Insurance Carrier Representative	For TDI-DWC Use Only
32. Printed Name of Adjuster or Authorized Insurance Carrier Representative	
33. Title of Adjuster or Authorized Insurance Carrier Representative	
34. Date of Signature	



**REQUEST FOR RME: APPROPRIATENESS OF HEALTH CARE RECEIVED (Complete Sections VII and VIII)**

**VII. EXAMINATION INFORMATION**

35. Examining RME Doctor's Name	36. RME Doctor's Mailing Address (Street or PO Box, City State Zip)	37. RME Doctor's License Number
38. RME Doctor's Telephone Number ( )	39. Examination Location (Street, City State Zip)	40. Date and Time of Appointment
41. Date of Prior Examination	42. Prior Examining Doctor's Name	
43. If different doctors are named in Boxes 35 and 42, explain the reason for requesting a different doctor.		
44. Does the claim involve medical benefits provided through a Certified Health Care Network? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the network.		
45. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the health care plan.		
46. Are the employee's address (Box 3) and the examination location (Box 39) more than 75 miles apart? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain why the employee is being required to travel more than 75 miles for the examination.		

**VIII. INSURANCE CARRIER CERTIFICATION**

47. I hereby certify the following:

- This request is complete and accurate.
- I have obtained the injured employee's agreement or attempted to obtain the injured employee's agreement for an examination under Texas Labor Code §408.004 (Appropriateness of Health Care Examination) as follows:

**Check ONLY ONE box below as applicable and provide date(s) as indicated for that box:**

Injured employee/attorney notified insurance carrier of agreement to attend examination by carrier's doctor on (mm/dd/yyyy) \_\_\_\_\_

Injured employee/attorney notified insurance carrier of non-agreement to attend examination by carrier's doctor on (mm/dd/yyyy) \_\_\_\_\_

Sent to injured employee/attorney on (mm/dd/yyyy) \_\_\_\_\_ and no reply received as of (mm/dd/yyyy) \_\_\_\_\_

- The insurance carrier will pay reasonable expenses incident to the examination of the injured employee.
- The selected doctor does not have a disqualifying association.
- I am authorized to act on behalf of the insurance carrier.

I understand that misrepresenting a workers' compensation claim may result in enforcement action including administrative penalties and fines.

48. Signature of Adjuster or Authorized Insurance Carrier Representative	49. Date of Signature
50. Printed Name of Adjuster or Authorized Insurance Carrier Representative	51. Title of Person Signing

**IX. INJURED EMPLOYEE AGREEMENT/NON-AGREEMENT**

52. Complete this section and return a copy of this form to the insurance carrier ONLY if Section VII above has been completed.

I agree  I do not agree - to attend the requested examination to determine whether health care I have received was appropriate.

**NOTE: If you agree, you must attend the examination at the time and location scheduled. If you do not agree, the insurance carrier will submit the request to TDI-DWC for review. If TDI-DWC approves the request, you will be issued an order to attend the examination.**

53. Signature of Injured Employee or Injured Employee's Attorney/Representative	For TDI-DWC Use Only
54. Printed Name of Injured Employee or Injured Employee's Attorney/Representative	
55. Date of Signature	

**NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).**



## Information for the Injured Employee

### For what purposes may a Required Medical Examination be requested?

DWC Form-022 *Required Medical Examination - Request for Agreement / Request for Order* is an insurance carrier's request for you to be examined by a doctor of the insurance carrier's choice. This examination is called a Required Medical Examination, or RME.

- **Request for Order (Evaluation of Designated Doctor Determination):** If you have been examined by a Designated Doctor, the insurance carrier may ask TDI-DWC to order you to attend an RME to address the same issue(s) the Designated Doctor addressed.
- **Request for Agreement/Order (Appropriateness of Health Care Received):** The insurance carrier may use the form to request your agreement to attend an RME to determine whether health care you have received was appropriate. You have 15 days from the date the carrier sent the request to you to complete *Section IX. INJURED EMPLOYEE AGREEMENT/NON-AGREEMENT* and return the form to the insurance carrier. You should keep a copy for your records. If you do not agree to attend the RME, the insurance carrier may ask TDI-DWC to order you to attend.

**Exception for Network Claims:** If you received medical benefits through a certified workers' compensation health care network, the insurance carrier is **not** permitted to request an RME on the appropriateness of health care received.

**Exception for Certain Political Subdivision Claims:** If you received medical benefits through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool, the insurance carrier is **not** permitted to request an RME unless the RME is necessary to resolve a question relating to the entitlement to or amount of income benefits.

### How often can a Required Medical Examination be performed?

An RME to determine appropriateness of health care received may not be performed more than once every 180 days. Examinations to evaluate a Designated Doctor determination may be performed more frequently. After you have received Supplemental Income Benefits for eight quarters, an RME to evaluate a Designated Doctor determination regarding your ability to return-to-work may be performed no more than once per year.

### What will TDI-DWC do?

Within 7 days of receiving the insurance carrier's request for an RME, TDI-DWC will approve or deny the request.

If TDI-DWC **approves** the insurance carrier's request or you agree to attend the RME, TDI-DWC will issue an order requiring you to attend.

**NOTE:** *If the request is approved, your failure to attend the scheduled RME may be considered an administrative violation and may result in suspension of temporary income benefits, if applicable. You may request that your treating doctor attend the RME.*

If TDI-DWC **denies** the insurance carrier's request, you will receive a copy of the denial order. In that case you will not be required to attend the RME.

### Can the RME appointment be rescheduled?

If you cannot attend an RME, you must contact the doctor's office to reschedule the examination at least 24 hours in advance. The rescheduled appointment must be no later than 7 days after the original appointment unless you and the doctor agree on a different date that is no later than 30 days after the original appointment.

### Questions / Information Regarding Travel Reimbursement

If you have questions regarding this form, need to request an accommodation under Title II of the Americans with Disabilities Act (ADA), or need information about reimbursement of travel expenses, contact TDI-DWC by calling (800) 252-7031. To request travel reimbursement, you must use the DWC-Form 048 *Request for Travel Reimbursement* which is available at <http://www.tdi.state.tx.us/forms/formlisting.html>.

## Instructions for the Insurance Carrier

### RME regarding Evaluation of Designated Doctor Determination

- After completing Sections I, II, and III, complete Sections IV, V and VI regarding an Evaluation of Designated Doctor Determination RME.
- Check the applicable box(es) in Section V, Box 29 to describe the reason(s) for the examination.
- Fax the request to TDI-DWC at (512) 804-4378.

### RME regarding Appropriateness of Health Care Received

- After completing Sections I, II, and III, complete Section VII regarding an Appropriateness of Health Care Received RME.
- Attempt to obtain agreement by sending the form to the injured employee and the injured employee's attorney or representative, if any.
- Upon obtaining the employee's answer in writing or by telephone or after 15 days with no response, complete Section VIII. In this section you must indicate whether the injured employee agreed, refused to agree, or failed to respond to the request.
- Fax the request to TDI-DWC at (512) 804-4378.