Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645
(512) 804-4380 phone • (512) 804-4121 fax

Complete, if known:

DWC Claim #

Carrier Claim #

Request for Designated Doctor Examination

Type (or print in black ink) each item on this form

I. INJURED EMPLOYEE INFORMATION

1. Employee Name (First, Middle, Last)	**2. Employee Social Security Number**
3. Employee Address (Street or P.O. Box, City, State, Zip Code)	**4. Employee County**
5. Employee Primary Phone Number ( )	**6. Employee Alternate Phone Number** ( )
7. Employee Date of Birth (mm-dd-yyyy)	**8. Date of Injury** (mm-dd-yyyy)

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

9. Employer Name	**10. Employer Phone Number** ( )
11. Employer Address (Street or P.O. Box, City, State, Zip Code)	

III. INSURANCE CARRIER INFORMATION

12. Insurance Carrier Name	
13. Insurance Carrier Address (Street or P.O. Box, City, State, Zip Code)	
14. Adjuster Name (First, Middle, Last)	**15. Adjuster E-mail Address**
16. Adjuster Phone Number ( )	**17. Adjuster Fax Number** ( )
Only Insurance Carriers Complete Boxes 18 - 22	
18. Insurance Carrier's Authorized Agent Company Name	
19. Insurance Carrier's Bill Review Agent Name	
20. Bill Review Agent Address (Street or P.O. Box, City, State, Zip Code)	
21. Bill Review Agent Phone Number ( )	**22. Bill Review Agent Fax Number** ( )

IV. INJURED EMPLOYEE REPRESENTATIVE INFORMATION *(if any)*

23. Representative's Name (First, Middle, Last)	**24. Representative's Phone Number** ( )
25. Representative's E-mail Address	**26. Representative's Fax Number** ( )

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V. TREATING DOCTOR INFORMATION

27. Treating Doctor Name	**28. Treating Doctor Phone Number** ( )
29. Treating Doctor Address (Street or P.O. Box, City, State, Zip Code)	**30. Treating Doctor Fax Number** ( )
31. Treating Doctor License Number	**32.Treating Doctor License Type**

VI. DESIGNATED DOCTOR SELECTION INFORMATION

33. Does the claim involve medical benefits provided through a Certified Workers' Compensation Health Care Network? ☐ Yes ☐ No If yes, provide the name of the network.

34. 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? ☐ Yes ☐ No
If yes, provide the name of the health care plan.

35. Check all body parts and diagnoses that apply:	**Examples (not an exhaustive list)**
☐ Spine and Torso	Cervical, Thoracic, Lumbar, Sacroiliac, Sacrum, Coccyx, Pelvis, Sternum and Manubrium, Rib Cage, Chest Wall, Abdominal Wall
☐ Upper Extremities	Shoulder including Glenohumeral and Acromioclavicular Joints, Clavicle, Sternoclavicular Joint, Scapula, Forearm, Arm, Elbow, Wrist, Hand, Finger
☐ Lower Extremities (excluding feet)	Hip, Buttock, Thigh, Leg, Knee
☐ Feet	Foot, Heel, Toe
☐ Teeth and Jaw	Tooth, Jaw, Temporomandibular Joint (TMJ)
☐ Eyes	Eye, Eyelid
☐ Other Body Areas or Systems	Internal Systems; Ear, Nose, and Throat; Head and Face; Skin; Mental and Behavioral Disorders; Tendon Lacerations; Dislocations
☐ Traumatic Brain Injury	N/A
☐ Spinal Cord Injuries	Spinal cord injuries, including spinal fractures with documented neurological deficit
☐ Severe Burns (including chemical burns)	3rd or 4th degree over 9% or greater of the body
☐ Multiple Bone Fractures (excluding spinal fractures)	N/A
☐ Infectious Diseases (complicated)	Infection requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens
☐ Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)	N/A
☐ Chemical Exposure (excluding chemical exposure limited to skin exposure)	N/A
☐ Heart or Cardiovascular Condition	N/A

Employee's Name:

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VII. EXAMINATION / INJURY INFORMATION

36. Provide the specific reason(s) for the requested examination. The reason(s) must indicate how the examination will resolve a dispute or assist in the progression of the claim.

37. List all injuries determined to be compensable by TDI-DWC or accepted as compensable by the insurance carrier. (If using ICD codes, you must also provide descriptions.)

38. Has a previous designated doctor examination been performed for this claim?
☐ Yes ☐ No If No, skip boxes 39 - 41.

39. Regarding the most recent designated doctor examination, provide the following information:

a. Name of the designated doctor

b. Date of the examination (mm/dd/yyyy)

40. If approval of this request would result in the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) scheduling an examination within 60 days of a previous designated doctor examination, provide good cause as to why it is necessary to schedule this examination within 60 days.

41. Explain any change of medical condition since the most recent designated doctor examination.

Employee's Name:

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VIII. PURPOSE FOR EXAMINATION

42. Requester: For items A through G below, check the box(es) next to the issue(s) you want the designated doctor to address and provide the requested information.

Designated Doctor: Address only the issues that are checked. If Box A or B is checked, you must file the DWC Form-069. If Box E or F is checked, you must file the DWC Form-073. If Box C, D or G is checked, you must file the DWC Form-068.

☐ **A. Maximum Medical Improvement (MMI)**

Statutory MMI Date (if any) _____ (mm/dd/yyyy)

Questions for the Designated Doctor to consider in the examination:
Has MMI been reached; if so, on what date (may not be greater than the statutory MMI date shown above)?

☐ **B. Impairment Rating (IR)**

MMI Date* (required only if Box A is not checked) _____ (mm/dd/yyyy)

*The MMI date that has been determined to be valid by a final decision of the TDI-DWC or court or by agreement of the parties.

Question for the Designated Doctor to consider in the examination: As of the MMI date, what is the IR?

☐ **C. Extent of Injury**

List all injuries (diagnoses/body parts/conditions) in question, claimed to be caused by, or naturally resulting from the accident or incident.

Describe the accident or incident that caused the claimed injury.

Question for the Designated Doctor to consider in the examination: Was the accident or incident giving rise to the compensable injury a substantial factor in bringing about the additional claimed injuries or conditions, and without it, the additional injuries or conditions would not have occurred? Include an explanation of the basis for your opinion.

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☐ **D. Disability – Direct Result** (check only if the injured employee is unable to obtain and retain employment at wages equivalent to the pre-injury wage)

Provide the beginning and ending* dates for the claimed periods of disability. If multiple periods, list all dates.
From _____ to _____ (mm/dd/yyyy)

*The ending date cannot be a future date. You may enter "present" for the ending date.

Question for the Designated Doctor to consider in the examination: Is the employee's inability to obtain and retain employment at wages equivalent to the pre-injury wage a direct result of the compensable injury?

☐ **E. Return to Work**

Provide the beginning and ending dates for each period covered by this request only if you are requesting the designated doctor to examine the injured employee's work status for a time other than the present. If multiple periods, list all dates.

From _____ to _____ (mm/dd/yyyy)

Questions for the Designated Doctor to consider in the examination:
Is the injured employee able to return to work in any capacity and what work activities can the injured employee perform?

☐ **F. Return to Work (Supplemental Income Benefits)**

Provide the beginning and ending dates for each qualifying period covered by this request. If multiple periods, list all dates. From _____ to _____ (mm/dd/yyyy)

Is the above qualifying period(s) applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? ☐ Yes ☐ No

NOTE: Injured employees are allowed only one designated doctor examination per year after the second anniversary (8th quarter) of Supplemental Income Benefits.

Question for the Designated Doctor to consider in the examination: Has the injured employee's medical condition improved sufficiently to allow the employee to return to work in any capacity for the identified qualifying period(s)?

☐ **G. Other Similar Issues**

Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s).

NOTE: Designated Doctor examinations **may not** be requested for developing treatment plans, determining appropriateness of medical care, or determining compensability.

Employee's Name:

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IX. REQUESTER CERTIFICATION

43. Check the appropriate box:

☐ **Injured Employee** ☐ **Injured Employee Representative** ☐ **Insurance Carrier** ☐ **TDI-DWC**

I certify the following:

- I am authorized to request the examination;
- All the information provided on this form is true and correct; and
- I provided a copy of this request to all parties at the time the original request was submitted to TDI-DWC.

I understand that any misstatement, falsification, or omission could cause an incorrect selection of the designated doctor and may result in the TDI-DWC voiding any order issued pursuant to the request or taking enforcement action, including administrative penalties and/or fines.

If "insurance carrier" is checked above, I further certify the following:
I have been authorized by the insurance carrier to provide employees of the company named in Section III, Box 18, with the insurance carrier's authorization to take all further actions and communicate with the TDI-DWC regarding this DWC Form-032 *Request for Designated Doctor Examination.* Inquiries may be made in order to:

- check the status of the request;
- inquire about the reason the request was denied;
- inquire about information for the scheduled examination; and
- inquire about any other information related to the request for the examination.

44. Signature of Requester	
45. Printed Name of Requester	**46. Date of Signature** (mm/dd/yyyy)

Employee's Name:

DWC Claim Number:

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Frequently Asked Questions
Request for Designated Doctor Examination (DWC Form-032)

Who may request that a designated doctor examination be ordered?
The injured employee, the injured employee's representative, or the insurance carrier may request the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to order a designated doctor examination. The TDI-DWC may also order a designated doctor examination on its own motion.

How often can a designated doctor examination be performed?
Prior to Supplemental Income Benefits (SIBs) eligibility and during the first eight quarters of receiving SIBs, a designated doctor examination may not be performed more than once every 60 days. The TDI-DWC may approve additional requests for an examination within the 60-day period if good cause exists. After eight quarters of SIBs, a designated doctor examination may be performed no more than once per year.

Do I have to complete all the fields on the DWC Form-032?
Failure to provide all required information on the DWC Form-032 may cause a delay in processing and your request may be returned to you.

If the injured employee does not have a treating doctor, you must specify *"No Treating Doctor"* in the space provided for the treating doctor's name in Box 27. If any other requested information is not applicable, answer "N/A".

Where do I file the DWC Form-032?
You are ***required to provide a copy of the completed DWC Form-032 to all parties*** at the time you submit the original request to the TDI-DWC. Submit the completed form to TDI-DWC by fax to (512) 804-4121 or by mail to the address shown below.

Texas Department of Insurance
Division of Workers' Compensation
Designated Doctor Examination Request Processing & Monitoring
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645

What does TDI-DWC do?
If the request is approved, the TDI-DWC assigns a qualified designated doctor to examine the injured employee. If there is a designated doctor who was previously assigned to the claim, the same doctor will be used as long as the doctor is still qualified and available. If the request is approved, within 10 days the TDI-DWC will issue an order to the parties regarding the examination. If the request is denied, you will receive a notice providing you with the specific reason(s) for the denial.

If you wish to dispute the TDI-DWC's approval or denial of a *Request for Designated Doctor Examination*, you are entitled to seek an expedited Contested Case Hearing under 28 Texas Administrative Code §140.3.

Where do I find more information on the designated doctor process?
For more information contact your local TDI-DWC Field Office at 1-800-252-7031. Additional resources that answer common questions about the designated doctor process are also available on the TDI website at http://www.tdi.texas.gov/wc/dd/.

NOTE[1]: Title 28 Texas Administrative Code §127.1(b) (9) requires that in order to request a designated doctor examination, a request must be submitted on the form prescribed by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: 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).