

Designated Doctor Requests Reexam In Response to Request for Clarification (LRE)

**TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
(CITY) FIELD OFFICE
(CITY), TEXAS**

(NAME),
CLAIMANT

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**DWC No. 00-123456-01
Carrier Claim # XXXXXXXX
Date of Injury: MM/DD/YYYY**

(NAME),
CARRIER

ORDER FOR DESIGNATED DOCTOR RE-EXAMINATION

On the ___ day of _____, 20___, the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) considered a request from (Party Identification) dated, (DATE), for clarification of the (DATE) report of Dr. _____, the designated doctor appointed to determine the issue(s) of _____ regarding the above-entitled claim.

Dr. _____ has notified TDI-DWC that an examination is necessary in order to adequately respond to the request for clarification.

TDI-DWC has determined that an examination is necessary to resolve an issue regarding the designated doctor's report.

IT IS THEREFORE ORDERED that an examination be conducted on the issue(s) of **(MMI/IR/EXTENT/RTW/DISABILITY/SIBS/OTHER)** to address the following questions:

*******Insert Questions for Doctor*******

IT IS FURTHER ORDERED that (Party Designation), (NAME), complete a new DWC Form-032, *Request for Designated Doctor Examination*, on the issue(s) of

(MMI/IR/EXTENT/RTW/DISABILITY/SIBS/OTHER) and file the same with the TDI-DWC within 10 days following the date of this order. Failure to timely comply with this order will result in an administrative violation referral, pursuant to Texas Labor Code §415.021(a).

Upon receipt and approval of the required DWC Form-032, *Request for Designated Doctor Examination*, the TDI-DWC will issue a Commissioner Order *Approval of Request for Designated Doctor Examination*, notifying parties of the date and time of the examination.

Signed this * day of *, 20**.

(Typed Name)
Benefit Review Officer

Cc: All Parties