TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Complete if known:

DWC claim #

Insurance carrier claim #

Request for a required medical examination (RME)

Este formulario está disponible en español en el sitio web de la División en www.tdi.texas.gov/forms/form20numeric.html
Para obtener asistencia en español, llame a la División al 800-252-7031.

Section 1: Claim information

Part 1: Employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Phone number	**4. Address** (street or PO box, city, state, ZIP code)
5. Date of injury (mm/dd/yyyy)	**6. Representative's name** (if any)
7. Representative's phone number	**8. Representative's address** (street or PO box, city, state, ZIP code)

Part 2: Insurance carrier information

9. Name	**10. Address** (street or PO box, city, state, ZIP code)
11. Adjuster's name (first, last)	**12. Adjuster's email**
13. Adjuster's phone number	**14. Authorized agent's company name**
15. Adjuster's fax number	**16. Authorized agent's phone number**

17. Are the medical benefits for this claim from a certified health care network?

☐ Yes ☐ No If yes, provide the name of the network.

18. Are the medical benefits for this claim from a political subdivision under Labor Code Section 504.053? ☐ Yes ☐ No If yes, provide the name of the health care plan.

Section 2: Examination information

19. Doctor's name	**20. Doctor's license number**
21. Doctor's phone number	**22. Date and time of appointment** (mm/dd/yyyy)

Employee's name: DWC claim number:		For DWC use only

23. Examination location (street, city, state, ZIP code)

24. Is the examination location more than 75 miles from the employee's address?
☐ Yes ☐ No If yes, explain why the employee is required to travel.

Section 3: Purpose of examination (Complete only Part 1 or Part 2)

Part 1: Issues previously addressed by a designated doctor (Check all that apply)

☐ Maximum medical improvement
☐ Impairment rating
☐ Extent of injury
☐ Disability – direct result
☐ Return to work
☐ Return to work (supplemental income benefits)
☐ Other similar issues

Part 2: Appropriateness of health care

25. Date of previous examination (if any) (mm/dd/yyyy)

26. Are you requesting that the employee see a different doctor than the one who performed the previous examination? ☐ Yes ☐ No If yes, provide the doctor's name and reason for using a different doctor.

27. Receipt of employee's agreement for an examination under 28 Texas Administrative Code Section 126.5(e). (Check only one box and provide dates.)

☐ Employee or representative notified the insurance carrier and agreed to attend the examination on (mm/dd/yyyy) .

☐ Employee or representative notified the insurance carrier and did not agree to attend the examination on (mm/dd/yyyy) .

☐ Insurance carrier sent this form to employee or representative on (mm/dd/yyyy) and no reply was received as of (mm/dd/yyyy) .

28. Employee's agreement to attend the requested examination ☐ I agree ☐ I do not agree

Note: If the employee agrees, they must attend the examination at the scheduled time and location. If the employee does not agree, the insurance carrier will submit the request for an RME to DWC for review. If DWC approves the request, DWC will issue an order for the employee to attend the examination under Texas Labor Code Section 408.004.

Signature	**Date**

Section 4: Certify with your signature

29. I certify that this request is complete and accurate. The doctor listed does not have a disqualifying association, and I am authorized to act on behalf of the insurance carrier.

Signature	**Date**
30. Printed name	**31. Job title**

Employee's name: DWC claim number:		For DWC use only

FAQ

Request for a required medical examination (RME)

Why would an insurance carrier request an RME?
The insurance carrier may request this examination for:

- **Issues ordered to be addressed in a designated doctor report:** To have a doctor of their choice check the same issues as the designated doctor and provide their opinion for each examination.
- **Appropriateness of health care:** To have a doctor of their choice examine whether the health care the injured employee received is appropriate and provide an opinion. The carrier can't request an exam for appropriateness of health care if the claim is in a health care network or political subdivision.

Where should the insurance carrier send this form?

- **Fax:** 512-804-4378
- **Mail:** Texas Department of Insurance, Division of Workers' Compensation
  Claims and Customer Services, Mail Code CCS
  PO Box 12050
  Austin, TX 78711-2050

Does the employee need to sign the form?
The employee only needs to sign the form when the purpose of the RME is for appropriateness of health care.

What does DWC do?
DWC will approve or deny the request and send the order to all parties.

Can the RME be rescheduled?
Yes, the employee and RME doctor must contact each other 24 hours or earlier before the examination date to reschedule. If the employee fails to attend the examination, DWC may submit an administrative violation.

What if the employee must travel to the RME?
If the examination is 30 miles or more from where the employee lives, the employee may request reimbursement for travel expenses from the insurance carrier using DWC Form-048, *Request for Travel Reimbursement* at www.tdi.texas.gov/forms/formlisting.html.

Questions?
Call 1-800-252-7031, Monday to Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.