TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation (MS-603)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4380 | F: (512) 804-4121 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

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)
9. Representative's Name (First, Middle, Last)	**10. Representative's Phone Number** ( )
11. Representative's Email Address	**12. Representative's Fax Number** ( )
13. Employer Name	**14. Employer Phone Number** ( )
15. Employer Address (Street or P.O. Box, City, State, ZIP Code)	

II. INSURANCE CARRIER INFORMATION

16. Insurance Carrier Name	
17. Insurance Carrier Address (Street or P.O. Box, City, State, ZIP Code)	
18. Adjuster Name (First, Middle, Last)	**19. Adjuster Email Address**
20. Adjuster Phone Number ( )	**21. Adjuster Fax Number** ( )
22. 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.	
23. Does the claim involve medical benefits provided through a political subdivision under Labor Code §504.053(b)(2), 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.	
Only Insurance Carriers Complete Boxes 24 - 28	
24. Insurance Carrier's Authorized Agent Company Name	**25. Insurance Carrier's Bill Review Agent Name**
26. Bill Review Agent Phone Number ( )	**27. Bill Review Agent Fax Number** ( )
28. Bill Review Agent Address (Street or P.O. Box, City, State, ZIP Code)	

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III. TREATING DOCTOR INFORMATION

29. Treating Doctor Name	**30. Treating Doctor Phone Number** ( )
31. Treating Doctor Address (Street or P.O. Box, City, State, ZIP Code)	**32. Treating Doctor Fax Number** ( )
33. Treating Doctor License Number	**34.Treating Doctor License Type**

IV. DESIGNATED DOCTOR SELECTION INFORMATION

35. Check all body areas and diagnoses that apply:	**Examples (not an exhaustive list)**
☐ **Spine and Musculoskeletal Structures of Torso** **See below for spinal cord injuries, hernia*	Cervical, Thoracic, or Lumbar Regions, Herniated Disc, Rib Cage, Chest Wall, Abdominal Wall, Sprains or Strains
☐ **Upper Extremities**	Shoulder, Forearm, Arm, Elbow, Wrist, Hand, Finger Regions, Rotator Cuff Tear, Sprains or Strains
☐ **Lower Extremities (excluding feet)** **See below for multiple fractures, hip or pelvis fracture.*	Buttock, Thigh, Leg, Knee Regions, ACL Tear, Meniscus Tear, Sprains or Strains
☐ **Feet**	Toes, Heel
☐ **Teeth and Jaw**	Temporomandibular Joint (TMJ)
☐ **Eyes**	Eyelid, Foreign Body, Corneal Abrasion
☐ **Other Body Areas or Systems**	Ear, Nose, and Throat; Head and Face; Skin; Cuts to Skin involving Underlying Structures; Non-Musculoskeletal Structures of the Torso; Hernia; Respiratory; Endocrine; Hematopoietic; Urologic
☐ **Traumatic Brain Injury**	Concussion; Post-Concussion Syndrome
☐ **Spinal Cord Injury**	Spinal Fracture with documented neurological deficit; Cauda Equina Syndrome
☐ **Severe Burns (including chemical burns)**	2nd, 3rd, or 4th Degree; Deep Partial, or Full Thickness Burns
☐ **Multiple Fractures, Joint Dislocation, Hip or Pelvis Fracture**	N/A
☐ **Infectious Diseases (complicated)**	Infection requiring hospitalization or prolonged intravenous antibiotics, including Blood Borne Pathogens
☐ **Complex Regional Pain Syndrome**	N/A
☐ **Chemical Exposure**	N/A
☐ **Heart or Cardiovascular Condition**	N/A
☐ **Mental and Behavioral Disorders**	Post-Traumatic Stress Disorder (PTSD)

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V. PURPOSE FOR EXAMINATION

36. Requester: Check box(es) A through G next to the issue(s) you want the designated doctor to address and provide the requested information.

☐ **A. Maximum Medical Improvement (MMI)**	Statutory MMI Date (if any) _____ (mm/dd/yyyy)
☐ **B. Impairment Rating (IR)**	MMI Date* _____ (mm/dd/yyyy) (required only if Box A is not checked) *The MMI date determined valid by a final DWC decision, court, or agreement of the parties.

☐ **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 **and** describe the accident or incident that caused the claimed injury.

☐ **D. Disability – Direct Result** **Note:** Check only if the injured employee is unable to obtain and retain employment at wages equivalent to the pre-injury wage	Provide the claimed period of disability. If multiple periods, list all dates. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) *Ending date cannot be a future date. Write "present", if no specific ending date.
☐ **E. Return to Work**	Provide the period to be assessed. If multiple periods, list all dates. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
☐ **F. Return to Work (Supplemental Income Benefits)** **Note:** Only one designated doctor examination per year after the second anniversary (8th quarter) of Supplemental Income Benefits is allowed	Provide the period to be assessed. If multiple periods, list all dates. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Is the qualifying period(s) applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? ☐ Yes ☐ No
☐ **G. Other Similar Issues** **Note:** Designated doctor examinations may not be requested for developing treatment plans, determining appropriateness of medical care, or determining compensability	Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s).

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VI. QUESTIONS FOR THE DESIGNATED DOCTOR

Designated Doctor: Address issues that are identified in Section V of the form and consider the questions below. If Box **A** or **B** is checked, you must file DWC Form-069. If Box **E** or **F** is checked, you must file DWC Form-073. If Box **C**, **D,** or **G** is checked, you must file DWC Form-068.
If Box **A** is checked, has MMI been reached; if so, on what date (may not be greater than the statutory MMI date shown above)?
If Box **B** is checked, on the MMI date, what is the IR?
If Box **C** is checked, 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.
If Box **D** is checked, 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?
If Box **E** is checked, is the injured employee able to return to work in any capacity and what work activities can the injured employee perform?
If Box **F** is checked, 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)?

VII. EXAMINATION / INJURY INFORMATION

37. List all injuries accepted as compensable by the insurance carrier. (Provide descriptions if using ICD codes.)
38. List all injuries determined to be compensable by an Approved DWC Form-024, DWC decision & order, DWC Appeals Panel decision, or final court order, if applicable. (Provide descriptions if using ICD codes.)
39. If approval of this request would result in the Texas Department of Insurance, Division of Workers' Compensation (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.

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VIII. REQUESTER CERTIFICATION

40. Check the appropriate box:

☐ **Injured Employee** ☐ **Injured Employee Representative** ☐ **Insurance Carrier**

I certify the following:

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

I understand that any misstatement, falsification, or omission could cause an incorrect selection of the designated doctor and may result in DWC voiding any order issued pursuant to the request or taking enforcement action, including administrative penalties 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 II, Box 24, with the insurance carrier's authorization to take all further actions and communicate with 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.

41. Signature of Requester	
42. Printed Name of Requester	**43. Date of Signature** (mm/dd/yyyy)

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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 (DWC) to order a designated doctor examination. 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. 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 29. 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 DWC. Submit the completed form to 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 DWC do?
If the request is approved, 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. Within 10 days 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 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 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: With few exceptions, upon your request, you are entitled to be informed about the information DWC collects about you; get and review the information (Government Code §§552.021 and 552.023); and have DWC correct information that is incorrect (Government Code §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.