DWC DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form UR-01

Submit two copies of the completed, signed application and the complete Utilization Review (UR) Plan in compact discs or flash drives in word-searchable PDF format to: Division of Workers' Compensation, Attn: Medical Unit: Utilization Review Plan Approval, PO Box 71010, Oakland, CA 94612.

Select: ☐New Plan ☐Material Modification

1. UR Plan Information

Name of UR Plan Applicant:

Address: City:

State: Zip Code: Telephone Number:

Fax Number: E-mail address:

Type of Entity Filing: Choose an item.

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2. UR Plan Contact Person Information

First Name: Middle Initial: Last Name:

Title:

Address: City:

State: Zip Code: Telephone Number:

Fax Number: E-mail address:

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3. Medical Director Information

First Name: Middle Initial: Last Name:

Address: City:

State: Zip Code: Telephone Number:

Fax Number: E-Mail Address:

CA License No.: NPI:

Board Certified Specialty (if any):

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4. URAC Accreditation: Choose an item.

Accreditation Status:

Original accreditation date:

Most recent accreditation date: Expiration Date:

Comments:

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5. UR Plan Client and Vendor Information

List all entities that utilize or contract for UR Plan services. Use additional pages if necessary.

Does the UR Plan delegate any UR functions? ☐ YES ☐ NO

If yes, indicate to whom and which function for each delegation. Use additional pages if necessary.

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6. Material Modification to UR Plan

If applicable, describe the changes that were made.

Signature of authorized individual: I, the undersigned Medical Director of the UR Plan named herein, have signed this document with knowledge of its contents, and verify that they are true and correct to the best of my knowledge and belief. I further understand that the DWC's approval of the UR plan identified herein does not equate to approval of policies and procedures that are contrary to law, and any such approval is unintended.

Name of Medical Director:

Date: Signature: