PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE TO INJURED EMPLOYEE
- APPEAL A UTILIZATION REVIEW (UR) DETERMINATION

To the Industrial Accident Board of the State of Delaware sitting in and for

_____ County.

_____	)	_____	_____
Claimant,	)	SS#	Carrier File #
	)		
vs.	)	_____	
	)	Carrier / Self-Insurer Name	
_____	)	_____	_____
Employer.	)	Date of Injury	Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all partied in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

This petition is a *de novo* review of a UR determination, pursuant to Title 19 **Del.C.** §2322F(j) and 19 **DE Admin Code** 1341. Please provide the information below:

1. Date petitioner received the UR Determination via certified mail (appeal must be filed within 45 days from date of UR determination receipt). _____

2. Date (s), Practice Guideline(s), and Treatment(s) involved in the Utilization Review.

Date(s):	Practice Guideline(s):	Treatment(s):
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

3. Name and Address of the Health Care Provider(s) whose treatment was questioned in this UR.

Dated this _____ day of _____ A.D. 20 _____ .

_____
Name of Petitioning Party

_____
Address

_____
City, State, and Zip Code

_____
Phone Number