Form 310

REQUEST/APPEAL FOR ADDITIONAL MEDICAL INFORMATION

PLEASE PRINT OR TYPE

Claimant Name _____ Date of Birth _____
Address _____ Social Security Number _____
_____ Date of Injury _____
Telephone Number _____
Employer _____

Insurance Company, Third Party Administrator, Self Insured Employer, or Attorney
Name of Requesting Party_____
_____
_____

Telephone Number _____
Name of Insurance Carrier or Self Insured Employer _____
_____

Specific Medical Information Requested:
1. _____
2. _____
3. _____

Reasons Additional Medical Information is Needed:
_____
_____

Claimant
_____ **Yes**, I agree to release the additional requested information
_____ **No**, I do not agree to release the additional requested information for the following reason(s)

If **Yes**, you agree to release the additional requested information, please complete the medical provider list for the specific information and sign the "Authorized Release for Medical Information."

If **No**, the insurance carrier may request the Labor Commission, Division of Industrial Accidents to review the request and make a decision as to the relevance of the additional medical information requested. The decision by the Division of Industrial Accidents may be appealed by either party to the Adjudication Division of the Labor Commission.

_____ _____
Claimant Signature **Date**

This form must be returned to the Requesting Party by the claimant within 10 days of the date mailed.

Official Form 310 *Revised 2/09*
State of Utah ● Labor Commission ● Division of Industrial Accidents
160 East 300 South● P.O. Box 146610 ● Salt Lake City, UT 84114-6610 ● Telephone: (801) 530-6800
Fax: (801) 530-6804 ● Toll Free: (800) 530-5090 ● *www.laborcommission.utah.gov*

_____ The Insurance Carrier is requesting a review by the Industrial Accidents Division as to the relevance of the additional requested information. (A summary of the need for the additional information must accompany this form.)

Determination:

_____
_____
_____
_____

Reason for Determination:

_____
_____
_____
_____

Unable to make a determination for the following reason(s):

_____
_____
_____
_____

If unable to make a determination, the insurance carrier will have 15 days from the date of the signed determination in which to submit additional information for consideration. Absent any additional information the request for additional medical information is denied. Any determination made the Division of Industrial Accidents must be appealed to the Adjudication Division within 30 days from the date of the determination or the determination becomes final.

_____ _____

Signature of Staff Person Making Determination Date