MG-2.1

CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE

Doctor's Name	WCB Case Number	Carrier Case Number	Date of Accident

Patient	Patient's Social Security Number	Doctor's WCB Authorization Number

INSTRUCTIONS TO ATTENDING DOCTOR: **This form is not to be filed separately**. Attach to completed Form MG-2 if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K= **K**nee, S=**S**houlder, B=Mid and Low **B**ack, N=**N**eck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Service of Supporting Medical in WCB Case File:..... (attach if not in file) **Approval Requested for: (one request type only)**	CARRIER'S/EMPLOYER'S RESPONSE *(If request is denied, explain on reverse.)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
3. Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K= **K**nee, S=**S**houlder, B=**M**id and Low **B**ack, N=**N**eck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Service of Supporting Medical in WCB Case File:..... (attach if not in file) **Approval Requested for: (one request type only)**	CARRIER'S/EMPLOYER'S RESPONSE *(If request is denied, explain on reverse.)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
4. Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K= **K**nee, S=**S**houlder, B=**M**id and Low **B**ack, N=**N**eck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Service of Supporting Medical in WCB Case File:..... (attach if not in file) **Approval Requested for: (one request type only)**	CARRIER'S/EMPLOYER'S RESPONSE *(If request is denied, explain on reverse.)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
5. Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K= **K**nee, S=**S**houlder, B=**M**id and Low **B**ack, N=**N**eck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Service of Supporting Medical in WCB Case File:..... (attach if not in file) **Approval Requested for: (one request type only)**	CARRIER'S/EMPLOYER'S RESPONSE *(If request is denied, explain on reverse.)* ☐ Granted ☐ Granted without Prejudice ☐ Denied

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2. Identify statement(s) by Request No. 2, 3, 4 or 5.

Request #2: .....

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CONTINUED ON REVERSE

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HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request(s) for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I ☐ did / ☐ did not contact the carrier by telephone to discuss the additional variance request(s) before making the request(s). I contacted the carrier by telephone on (date)..... and spoke to (person spoke to or was not able to speak to anyone) .....

☐ A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund by (fax, email)....., a copy was sent (see addresses on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, to the claimant if not represented, and to any other parties of interest on the date below.

☐ I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on.....

Provider's Signature: ..... Date: .....

B. CARRIER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The carrier/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name)..... Title: .....

Signature: ..... Date: .....

C. CARRIER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

If any additional request(s) are denied, give reason(s) for denial below. Identify reasons according to Request No. 2-5 on the front of this form. (Attach written report of medical professional for each denial as explained on Form MG-2.)

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Name of the Medical Professional who Reviewed the Denial:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board (see fax and email addresses on instruction page), the claimant's legal counsel, if any, to the claimant, if unrepresented, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, on the date below.

(Please complete if request is denied.) If the Medical Provider requests a review of this denial, I opt for the decision to be made by the ☐ Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

By: (print name)..... Title: .....

Signature: ..... Date: .....

D. CLAIMANT'S REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S / CARRIER'S DENIAL

☐ I request that the Workers' Compensation Board review the carrier's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made by the ☐ Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

Claimant's Signature: ..... Date: .....

E. CARRIER'S/EMPLOYER'S GRANTING OF VARIANCE REQUEST THAT WAS INITIALLY DENIED

I certify that the provider's variance request initially denied above is now granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name)..... Title:.....

Signature:..... Date:.....