



Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Injured Employee: :
DWC Claim/Docket #:
Date of Injury: !
Employer:
Insurance Carrier: ?
Insurance Carrier Claim #: ?
Date: June 13, 2023

Dear

Request for information to the insurance carrier:

This case involves a dispute of a certification of maximum medical improvement or impairment rating (DWC Form-069, *Report of medical evaluation*). Pursuant to 28 Texas Administrative Code Section 102.9, we are requesting you to provide the following information:

1. The adjuster's name and contact information.
2. The treating doctor's name and contact information.
3. The name of the network, if applicable.
4. For each condition listed below, please indicate if the insurance carrier accepts or disputes the condition for purposes of maximum medical improvement or impairment rating:

Injury or Condition	Accepts	Disputes
1. Osteochondral fracture of talar dome	<input type="checkbox"/>	<input type="checkbox"/>
2. Tarsal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
2. Complex regional pain syndrome type I of right lower limb	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>

5. List any additional injuries that you believe should be considered when assessing maximum medical improvement or impairment rating. For each condition listed, indicate if the insurance carrier accepts or disputes the condition for purposes of maximum medical improvement or impairment rating.

Injury or Condition	Accepts	Disputes
1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>

Send this information to:

Angel Hendricks, Benefit Review Officer
 800-252-7031, Option 7, Extension 32913
 Fax: 512-804-4011; Email: Angel.Hendricks@tdi.texas.gov
 Mailing Address: PO Box 12050, Austin, TX 78711-2050

You must send this information by: Three business days

Questions?

Call 1-800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.

We sent a copy of this letter to:

JAMES SHEFFIELD III
 FLAHIVE OGDEN & LATSON
 PO BOX 201329
 AUSTIN TX 78720-1329