



Industrial Commission of Arizona
Medical Resource Office

MRO-2

REQUEST FOR ADMINISTRATIVE REVIEW
(Limited to chronic pain and/or opioids)

This is a request for an urgent or life-threatening condition

REASON FOR REVIEW

| |
|---|
| <input type="checkbox"/> Non-response from Payer |
| <input type="checkbox"/> Denial of requested medical treatment or services <input type="checkbox"/> Partial denial of requested medical treatment or services |
| <input type="checkbox"/> Multiple requests for denied medical treatment or services |
| <input type="checkbox"/> Payer's Initial Decision denies a request for medical treatment or services that is supported by the Guidelines |

EMPLOYEE INFORMATION

| | | | | |
|-------------------------------|--|------------------------------|---------|------------|
| Last Name*: | | First Name*: | | MI: |
| Address*: | | City*: | State*: | Zip Code*: |
| Phone*: | | E-mail Address: | | |
| Date of Injury (MM/DD/YYYY)*: | | Date of Birth (MM/DD/YYYY)*: | | |
| Payer Claim Number: | | SSN**: | | |
| ICA Case Number**: | | Employer: | | |
| Employee Attorney: | | Attorney Phone: | | |
| Attorney Address: | | E-mail: | | |

REQUESTING PROVIDER INFORMATION

| | | | | |
|------------|--------|----------------|--------|--|
| Name*: | | Contact Name*: | | |
| Address: | | City: | State: | |
| Zip Code: | Phone: | Fax Number: | | |
| Specialty: | | NPI Number*: | | |
| E-mail: | | | | |

PAYER INFORMATION

| | | | | |
|--------------|--------|----------------|--------|--|
| Payer Name*: | | Contact Name*: | | |
| Address: | | City: | State: | |
| Zip Code: | Phone: | Fax Number: | | |
| E-mail: | | | | |

REQUESTED TREATMENT: List each specific requested medical treatment or service below

| DIAGNOSIS ICD-Code* | Treatment/Services Requested* | CPT Code/NDC Code* |
|---------------------|-------------------------------|--------------------|
| | | |

REQUIRED ATTACHMENTS

- Copies of relevant medical information or records, including information pertaining to preauthorization request (e.g. request(s) and/or justification for treatment, applicable treatment guideline(s)), and if applicable, denial of treatment by payer.
- Copies of documentation related to the payer's decision or non-response.

| | | |
|---------------|------------|-------|
| Printed Name: | Signature: | Date: |
|---------------|------------|-------|

*Required Field

** ICA Claim Number or Social Security Number Required

INSTRUCTIONS FOR PROVIDER, INJURED EMPLOYEE OR EMPLOYEE REPRESENTATIVE: Submit completed form with supporting documents to The Industrial Commission of Arizona, Attn: Medical Resource Office, 800 W. Washington St, Suite 305, Phoenix, AZ 85007.

MRO Phone (602) 542-4308 MRO Fax: (602)542-4797 OR log onto MRO Portal at: <https://mro.azica.gov>

If Payer's Decision is supported by an IME, then review of that decision must be requested by the injured employee under A.R.S. § 23-1061(J).