



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Compliance & Investigations (MS-8)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4576 | (800) 252-7031 | TDI.texas.gov | @TexasDWC

## Request for Standard Detailed Data Reports

### I. INSURANCE CARRIER INFORMATION

Identify the insurance carrier (*including certified self-insurers, certified self-insurer groups, and governmental entities*) that submitted the claims data related to the standard detailed data reports.

**1. Insurance Carrier's Name**

**2. Insurance Carrier's Federal Employer ID Number (FEIN)**

**3. Insurance Carrier's Group Affiliation (if applicable)**

**4. Insurance Carrier's Primary Mailing Address (Street or P.O. Box, City, State, ZIP)**

The following boxes are to be completed with the insurance carrier's contact information confirming the company below is authorized to receive the insurance carrier's standard detailed data reports.

**5. Insurance Carrier Contact Name (First, Middle, Last)**

**6. Insurance Carrier Contact Phone Number**  
( )

**7. Insurance Carrier Contact Fax Number**  
( )

**8. Insurance Carrier Contact Email Address**

**9. Requesting ACTION:**

**Add**

**Remove**

**10. Effective Date**

### II. COMPANY AUTHORIZED TO RECEIVE

Identify the company authorized to receive the standard detailed data reports related to the insurance carrier listed above. DWC will establish a secure file transfer protocol (SFTP) box to provide the standard detailed data reports to the authorized requestor.

**11.  Insurance Carrier** (*includes certified self-insurers, certified self-insurer groups, and governmental entities*)

**Third Party Administrator**

**Electronic Data Interchange (EDI) Trading Partner**

**12. Company's Name**

**13. Company Federal Employer ID Number (FEIN)**

**14. Company Contact Name (First, Middle, Last)**

**15. Company Contact Working Title**

**16. Company Mailing Address (Street or P.O. Box, City, State, ZIP)**

**17. Company Contact Email Address**

**18. Company Contact Phone Number**  
( )

**19. Company Contact Fax Number**  
( )

### III. STANDARD DETAILED DATA REPORTS (*check all that apply*)

**20. Monthly performance scorecard detail**

*Initial temporary income benefit (TIBs) payment and EDI reporting*

*Medical bill processing and EDI reporting*

*Request for reconsideration medical bill processing and EDI reporting*

**One Time**  
(Specify Period)

**Monthly**

**Report Action**

**Add**  **Remove**

mm/dd/yyyy

**Add**  **Remove**

mm/dd/yyyy

**Add**  **Remove**

**21. Other (specify)**

**22. Other (specify)**

#### IV. INSURANCE CARRIER AFFIRMATION

Through the undersigned representative, the insurance carrier identified above authorizes DWC to release previously submitted claim data to the company authorized to receive the data reports, Section II, above. Through my signature below, I affirm my specific authority to execute this form on behalf of the insurance carrier. If applicable, I further affirm that the contract between the above-named authorized company and the insurance carrier requires that the workers' compensation information requested remains subject to the confidentiality requirements of Texas Labor Code, Title 5, Subtitle A, (Texas Workers' Compensation Act), and that the authorized company to which requested data may be transmitted shall store all such workers' compensation claim information in a secure environment with all appropriate security and privacy safeguards so as to prevent unauthorized access to, or disclosure of, the information.

<b>23. Signature of Insurance Carrier's Authorized Representative</b>	For DWC Use Only
<b>24. Insurance Carrier Authorized Representative's Printed Name</b>	
<b>25. Date of Signature</b>	

**NOTE:** With few exceptions, upon your request, you are entitled to be informed about information DWC collects about you; receive and review the information (Government Code §§552.021 and 552.023); and have DWC correct information that is incorrect (Government Code §559.004).

## Frequently Asked Questions Request for Standard Detailed Data Reports

### Who may request this information?

Companies authorized by insurance carriers, including certified self-insurers, certified self-insurer groups, and governmental entities, to receive standard detail data reports may request the information that the insurance carrier has already submitted to DWC be made available to them, on the insurance carrier's behalf.

### What types of standard detailed data reports are available?

Reports available are claim-level data already submitted to DWC by an insurance carrier. Some standard detail data reports are related to claims EDI data while others provide the detail behind the monthly performance scorecards for individual insurance carriers specifically related to:

- timely payment of TIBs and EDI reporting;
- timely processing of medical bills and EDI reporting; and
- timely processing of reconsideration medical bills and EDI reporting.

### How do I change who is authorized to receive standard detailed data reports or other information?

If any information reported on the DWC Form-029 changes, including the authorization status of the company receiving information on behalf of the insurance carrier or a standard detailed data report, file another DWC Form-029 within five working days.

### How will the standard detailed data reports be delivered to authorized requestors?

DWC will establish a secure file transfer protocol (SFTP) box to provide data to the requestor.

### How do I submit my request to DWC?

**Email:** [DWC-MA@tdi.texas.gov](mailto:DWC-MA@tdi.texas.gov)

or

**Mail:** Texas Department of Insurance  
Division of Workers' Compensation, MS-8  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744

### Questions?

If you have questions about this form or need more information about the standard detail data reports, contact Complaints and Investigations, Monitoring and Analysis section by email at [DWC-MA@tdi.texas.gov](mailto:DWC-MA@tdi.texas.gov).