**State of California, Division of Workers’ Compensation**

 **REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL**

**(Unrepresented Employee)**

**TO REQUEST A QUALIFIED MEDICAL EVALUTOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:**

1. **Complete this form (print or type the information). Sign and date at bottom.**
2. **If the request is made to determine if the injury is work-related, include a copy of the claims administrator’s notice that the claim was denied, or a copy of the claims administrator’s request for an evaluation.**
3. **Complete the attached Proof of Service.**
4. **For Employee: Mail the completed signed form and Proof of Service to:**

 **Division of Workers’ Compensation – Medical Unit**

**P.O. Box 71010, Oakland, CA 94612**

**(510) 286-3700 or (800) 794-6900**

**5. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**

**6. For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written**

 **objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to**

 **the Employee.**

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| **Panel Request Information :** **Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Specialty Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(Select only ONE specialty)****Requesting Party: [ ]  Employee [ ]  Claims Administrator [ ]  Defense Attorney**  |
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| **Reason for QME Panel Request (check one):**[ ]  To determine if the injury is work-related (attach claims administrator’s notice that claim was denied or a copy of the claims administrator’s request for an evaluation). [ ]  Objection to Primary Treating Physician’s determination regarding temporary disability, permanent disability, or the need for future medical care.[ ]  Work injury claim is accepted for one or more body parts, there is a dispute over additional body parts.[ ]  Other (specify non-medical treatment dispute): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Employee Information** |
| First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address or P.O. Box: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If currently not living in state, enter the California zip code on date of injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If never resided in state, enter the California zip code agreed on for the evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Employer/Claims Administrator Information** |
| Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claims Administrator Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster/Contact Name (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address or P.O. Box:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_ Phone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Requestor Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PROOF OF SERVICE** |
| **Instructions:****1.Complete the Proof of Service.****2. For Employee: Mail the completed signed form and Proof of Service to:**  **Division of Workers’ Compensation – Medical Unit****P.O. Box 71010, Oakland, CA 94612****(510) 286-3700 or (800) 794-6900****3. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.****4. For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written**  **objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to**  **the Employee.**  |

I declare that I am a resident of or employed in the county of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, California; I am over the age of eighteen years.

On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I served the attached completed Form 105 on the following parties:

by mail to:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Employee or Claims Administrator

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip code

 by hand-delivery to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip code

**I declare, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.**

**Executed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, California**

**Type or Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Use with the QME Panel Request Form 105**

**MD/DO SPECIALTY CODES**

MAA Anesthesiology

MAI Allergy & Immunology

MPA Pain Medicine MHH Orthopedic Surgery - Hand

MDE Dermatology MTO Otolaryngology

MAI Dermatology – Allergy & Immunology MHA Pathology

MEM Emergency Medicine MPR Physical Medicine & Rehabilitation

MTT Emergency Medicine – Toxicology MPA Physical Medicine & Rehabilitation – Pain Medicine
MFP Family Practice MPS Plastic Surgery (other than Hand)

MPM General Preventive Medicine MHH Plastic Surgery – Hand

MTT General Preventive Medicine – Toxicology MPD Psychiatry (other than Pain Medicine)

MMM Internal Medicine MPA Psychiatry – Pain Medicine

MAI Internal Medicine- Allergy & Immunology MSY Surgery (other than Spine or Hand)

MMV Internal Medicine – Cardiovascular Disease MHH Surgery - Hand

MME Internal Medicine – Endocrinology Diabetes & Metabolism MSG Surgery – General Vascular

MMG Internal Medicine – Gastroenterology MTS Thoracic Surgery

MMH Internal Medicine – Hematology MUU Urology

MMI Internal Medicine – Infectious Disease ***NON-MD/DO SPECIALTIES CODES***

MMO Internal Medicine – Medical Oncology ACA Acupuncture

MMN Internal Medicine – Nephrology DCH Chiropractic

MMP Internal Medicine – Pulmonary Disease DEN Dentistry

MMR Internal Medicine – Rheumatology OPT Optometry

MPN Neurology POD Podiatry

MPA Neurology – Pain Medicine PSY Psychology

MNS Neurological Surgery (other than Spine)

MNB Neurological Surgery – Spine

MOG Obstetrics & Gynecology

MOQ Medicine Otherwise Qualified

MPO Occupational Medicine

MTT Occupational Medicine – Toxicology

MOP Ophthalmology

MOS Orthopedic Surgery (other than Spine or Hand)

MNB Orthopedic Surgery - Spine

*Do not file this page with your form!*