DWC MEDICAL PROVIDER NETWORK (MPN)
COMPLAINT FORM 9767.16.5

Name of Person Filing Complaint: _____

Phone:_____ Email: _____

Address: _____ City_____State_____ Zip _____

Person Filing Complaint is: (Check one) ☐ Injured Employee ☐ Attorney ☐ Provider ☐ Other

Nature of Complaint: (Check all that apply):

☐ MPN Notice not provided ☐ Inaccurate MPN provider listing ☐ Unable to contact MPN

☐ Cannot access MPN website ☐ No MPN provider available ☐ Other:_____

Name of Employer_____

Name of MPN_____ MPN Approval or Log No: _____

Name of MPN Contact_____ MPN Contact Phone No:_____

Date MPN Contact Informed of Complaint _____

Provide a brief description of the complaint including the following information (attach additional pages as needed):

1) State the alleged violation:

2) State when the violation occurred and whether it is still occurring:

3) Describe specifically what attempts you have made with the MPN to address the violation:

4) Describe what, if any, impact there has been on an injured worker:

5) State what remedy you seek for the alleged violation:

Please submit form using one of the options below if not submitted online:
By Mail: DWC – MPN Unit, PO Box 420603, San Francisco, CA 94142-0603 and put Attn: MPN Complaints
By email: ManagedCare@dir.ca.gov and put MPN Complaint in subject line