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*State of California*
***DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT***
***REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2***
***REPRESENTED - for injuries occurring prior to January 1, 2005***
***(Please print or type)***

Date of Injury*(Required):* Claim Number *(Required)*: Specialty of Treating Physician *(Required)*:

Specialty Requested *(Required):* Opposing Party's Specialty Preference *(If known):*

**Requesting party** *(Required: check one box only)*

☐ Applicant's Attorney ☐ Defense Attorney /Claims Administrator

**Reason QME panel is being requested** (*Required: check one box only)*

☐ § 4060 (compensability exam) ☐ § 4061 (permanent disability dispute) ☐ § 4062 (non medical treatment dispute under 4062)

## Employee Information (*Required)*

First Name: Middle Initial: Last Name:

Mailing Address: 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:

**Answer each question below** *(Required)*

Has the employee ever had an AME/QME exam before? ☐ Yes ☐ No

If yes, has that claim been settled or resolved? ☐ Yes ☐ No

Is this a dispute about a current need for medical treatment? ☐ Yes ☐ No

Is this a dispute over an additional body part ? ☐ Yes ☐ No

If the employee has seen an AME/ QME for this injury, provide the information below:

Name of AME/QME seen:

Date of Exam:

Name of the Primary Treating Physician: Date of Report being objected to:

Describe the nature of the dispute that requires resolution:

## Employee's Attorney (*Required)*

First Name Last Name

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code Phone Number


*(Continue form on next page)*

Claim Number: _____

## Employer and Claims Administrator Information

Employer: _____

Claims Administrator Company Name: _____

Claims Adjustor Name: _____

Street Address or P.O. Box: _____

City: _____ State: ____ Zip Code: _____ Phone Number: _____

## Defendant's Attorney

_____ _____
First Name Last Name

_____
Law Firm Name

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ ____ _____ _____
City State Zip Code Phone Number

Date: _____

_____ _____
Print Name of Requestor Signature of Requestor

***Note: The party submitting this form must attach a copy of the written objection to an opinion of a treating physician identifying an issue in dispute.***

*The completed form must be mailed to*:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

*Declaration of Service*

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On _____ , I served this QME 106 form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

| | |
|---|---|
| A | depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid. |
| B | placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid. |
| C | placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier. |
| D | placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)* |
| E | personally delivering the sealed envelope to the person or firm named below at the address shown below. |

Method of Service _____ Person or firm served _____ Street Address : _____

City: _____ State _____ Zip Code: _____

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City: _____ State _____ Zip Code: _____

Method of Service _____ Person or firm served _____ Street Address : _____

City: _____ State _____ Zip Code: _____

Method of Service _____ Person or firm served _____ 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.

Date: _____ at _____ , California.

Type or print name _____

Signature _____

# For Use with the QME Panel Request Form 106

## *MD/DO SPECIALTY CODES*

| | |
|---|---|
| MAA | Anesthesiology |
| MAI | Allergy and Immunology |
| MDE | Dermatology |
| MEM | Emergency Medicine |
| MFP | Family Practice |
| MPM | General Preventive Medicine |
| MHH | Hand |
| MMM | Internal Medicine |
| MMV | Internal Medicine- Cardiovascular Disease |
| MME | Internal Medicine- Endocrinology Diabetes and Metabolism |
| MMG | Internal Medicine - Gastroenterology |
| MMH | Internal Medicine-Hematology |
| MMI | Internal Medicine-Infectious Disease |
| MMO | Internal Medicine - Medical Oncology |
| MMN | Internal Medicine-Nephrology |
| MMP | Internal Medicine-Pulmonary Disease |
| MMR | Internal Medicine-Rheumatology |
| MNB | Spine |
| MPN | Neurology |
| MNS | Neurological Surgery *(other than Spine)* |
| MOG | Obstetrics and Gynecology |
| MOQ | Medicine Otherwise Qualified |
| MPO | Occupational Medicine |
| MOP | Ophthalmology |
| MOS | Orthopaedic Surgery*(other than Spine or Hand)* |
| MTO | Otolaryngology |
| MPA | Pain Medicine |
| MHA | Pathology |
| MPR | Physical Medicine & Rehabilitation |
| MPS | Plastic Surgery *(other than Hand)* |
| MPD | Psychiatry *(other than Pain Medicine)* |
| MSY | Surgery*(other than Spine or Hand)* |
| MSG | Surgery-General Vascular |
| MTS | Thoracic Surgery |
| MTT | Toxicology |
| MUU | Urology |

## *NON-MD/DO SPECIALTY CODES*

| | |
|---|---|
| ACA | Acupuncture |
| DCH | Chiropractic |
| DEN | Dentistry |
| OPT | Optometry |
| POD | Podiatry |
| PSY | Psychology |

*Do not file this page with your form!*