**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!*