DWC Medical Provider Network Complaint Form 9767.16.5

Person filing compliant *(Completion of these fields is required)*

First Name ______ Last Name ______ E-mail Address ______ Phone Number ______

Mailing Address ______ City ______ State ______ Zip Code ______

Person filing the complaint is *(Check one)*: ☐ Injured worker ☐ Attorney ☐ Provider ☐ Other

Nature of the Complaint *(Check all that apply and provide sufficient details of the descriptions below)*

☐ Cannot access MPN website provider listing
☐ Unable to contact Medical Access assistant and/ or MPN contact
☐ Inaccurate MPN listing
☐ MPN notice not provided
☐ Physician or specialist not available in the MPN
☐ Other ______

Employer Name ______ MPN Name ______ MPN Identification No. ______

MPN Contact First Name ______ MPN Contact Last Name ______ MPN Contact E-mail ______ MPN Contact Phone ______

Date of Initial Written Complaint to MPN *(MM/DD/YYYY)* ______

Imminent Threat to an Injured worker? ☐ Yes ☐ No

Provide a brief description of the complaint *(Attach additional pages as needed)*

1. Describe or state the specific sections of the Labor Code or the MPN regulations violated:

2. State when the violation occurred and whether you believe the violation 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 because of the violation:

5. What result are you seeking because of the alleged violation:

Instructions for Formal Complaint Submission to DWC

Serve the MPN Contact listed above with a copy of this completed form and all supporting evidence; and submit this completed form with all supporting evidence and proof of service on the MPN Contact to: *DWC-MPN Complaints, P.O. Box 71010, Oakland, CA 94612*