



OBJECTION TO TREATING PHYSICIAN'S RECOMMENDATION FOR SPINAL SURGERY

EMPLOYEE				
Last Name	First Name	Other names/initials	Social Security Number	Date of Injury
W.C.A.B. Case No.				
RESIDENCE ADDRESS: Street		City	State	Zip Code
EMPLOYER				
Name				
MAILING ADDRESS: Street		City	State	Zip Code
Insurance Carrier:				
Claims Administrator:				
Company providing utilization review:				
Employer health care provider:				
EMPLOYEE'S ATTORNEY				
Name				
MAILING ADDRESS: Street		City	State	Zip Code
Telephone:		Fax Number:		
TREATING PHYSICIAN				
Last Name:	First Name:	Other names/initials:		
MAILING ADDRESS: Street		City	State	Zip Code
Telephone:		Fax Number:	E-mail:	
Physician's Medical Group:				
Independent Practice Association:				
Exact procedure which is being objected to:				
Name of facility or institution at which the proposed procedure is to be performed:				
Name of facility or institution at which an alternative procedure (if any) recommended by the employer, employer health care provider, carrier, or administrator is proposed to be performed:				

Date that the treating physician's recommendation for this procedure was first received by any of employer, insurance carrier, administrator:

Name of entity which received it on that date:

Type of entity (employer, insurance carrier, or administrator):

NAME OF PERSON SIGNING THIS OBJECTION:

Name: _____ Company: _____

MAILING ADDRESS: Street _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax Number: _____ E-mail: _____

Reason(s) for this objection, specific to this employee:

I declare under penalty of perjury of the laws of the State of California on (date) _____, that the enclosed physician's report was first received by the employer, insurance carrier or administrator on (date) _____, and that on (date) _____, I served the enclosed objection on:

(name of person served)	(means of service: e.g. mail/certified mail/fax/FedEx)	(time, if by fax)
ADMINISTRATIVE DIRECTOR		

(Signature)

The declaration and this form must be signed by a Principal or Employee of the employer, insurance carrier, or administrator.

This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 8888, San Francisco, CA 94128-8888, and copies served by mail or other rapid means of delivery (such as fax or overnight delivery) on the employee, employee's attorney, and treating physician. This Objection is to be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.