State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2
REPRESENTED

~~(For dates of injury on or after 1/1/2013~~ *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 (*Required)*

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 or the written request for a QME to resolve an issue of compensability.

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

~~***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.***~~

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 show below.

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:

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 106a

MD/DO SPECIALTY CODES

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

MMN Internal Medicine-Nephrology

MMO Internal Medicine- Oncology

MMP Internal Medicine-Pulmonary Disease

MMR Internal Medicine-Rheumatology

MNB Spine

MPN Neurology

MNS Neurological Surgery *(other than Spine)*

MOG Obstetrics and Gynecology

MPO Occupational Medicine

~~MMO Oncology- Orthopaedic Surgery Internal Medicine or Radiology~~

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

PSN Psychology -Clinical Neuropsychology

Do not file this page with your form!