DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK FORM 9767.17.5 (PART B)

Print Form

Reset Form

The MPN to complete all required fields and state the reasons why Petition should not be granted below

Petitioner's Information

First Name | Last Name | Phone Number | Petitioner E-mail

MPN Information

MPN Name | MPN Applicant Name | MPN Identification No.

Date MPN Received Petition *(MM/DD/YYYY)*

MPN Contact Information

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

MPN Authorized Individual Information

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

State reasons why petition should not be granted (additional pages and documents may be attached):

Verification

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____ (City), California on _____ *(MM/DD/YYYY)*

_____ (Name of Authorized Individual) By: _____ (Signature of Authorized Individual)

NOTICE TO MPN

Proof of Service is Required: A proof of service by mail showing a copy of the response has been served on the Petitioner and Administrative Director must be attached and submitted with this form and all supporting documentation within ***30 days*** from the date the petition was served on the MPN.