

State of California, Division of Workers' Compensation
REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUATOR (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.

Panel Request Information :

Date of Injury: _____ Claim Number: _____ Specialty Requested: _____
(Select only ONE specialty)

Requesting Party: Employee Claims Administrator Defense Attorney

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:** _____

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	MHH Orthopedic Surgery - Hand
MPA Anesthesiology — Pain Medicine	MTO Otolaryngology
MDE Dermatology	MPA Pain Medicine
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	<i>NON-MD/DO SPECIALTIES CODES</i>
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!