PRINT CLEAR

State of California, Division of Workers' Compensation

REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUTOR (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:_____

MD/DO SPECIALTY CODES

MAA Anesthesiology
MAI Allergy & Immunology
MPA Pain Medicine
MDE Dermatology
MAI Dermatology – Allergy & Immunology
MEM Emergency Medicine
MTT Emergency Medicine – Toxicology
MFP Family Practice
MPM General Preventive Medicine
MTT General Preventive Medicine – Toxicology
MMM Internal Medicine
MAI Internal Medicine- Allergy & Immunology
MMV Internal Medicine – Cardiolvascular Disease
MME Internal Medicine - Endocrinology Diabetes & Metabolism
MMG Internal Medicine – Gastroenterology
MMH Internal Medicine – Hematology
MMI Internal Medicine – Infectious Disease
MMO Internal Medicine – Medical Oncology
MMN Internal Medicine – Nephrology
MMP Internal Medicine – Pulmonary Disease
MMR Internal Medicine – Rheumatology
MPN Neurology
MPA Neurology – Pain Medicine
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
MHH Orthopedic Surgery - Hand
MTO Otolaryngology
MHA Pathology
MPR Physical Medicine & Rehabilitation
MPA Physical Medicine & Rehabilitation – Pain Medicine
MPS Plastic Surgery (other than Hand)
MHH Plastic Surgery – Hand
MPD Psychiatry (other than Pain Medicine)
MPA Psychiatry – Pain Medicine
MSY Surgery (other than Spine or Hand)
MHH Surgery - Hand
MSG Surgery- General Vascular
MTS Thoracic Surgery
MUU Urology

NON-MD/DO SPECIALTIES CODES

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology

Do not file this page with your form!