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)

Request Date *(Required)*: ______ 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: ______

Street 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 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

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

____
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

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.

For Use with the QME Panel Request Form 106

MD/DO SPECIALTY CODES

Code	Specialty
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
MMH	Internal Medicine-Hematology
MMI	Internal Medicine-Infectious Disease
MMN	Internal Medicine-Nephrology
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

Code	Specialty
ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology -Clinical Neuropsychology

Do not file this page with your form!