

**HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR
IF YOU DO NOT HAVE AN ATTORNEY
(Attachment to **Form 105**)**

The purpose of a Qualified Medical Evaluator (QME) examination is to obtain a second medical opinion to help resolve disputed medical issues in your workers' compensation claim(s). If you are an injured worker who is not represented by an attorney, use QME Form 105 to obtain a panel of three QMEs, one of which will examine you in the event there is a disagreement over some of the opinions of your treating physician or there is a need to determine if the claimed injury is work related. The QME report must discuss all of the disputed and unresolved issues in your claim that need a medical opinion. An injured worker has the first opportunity to choose the type of physician to perform the exam. If you are an injured worker requesting a QME panel, write the medical specialty you prefer for the QME where indicated, complete the rest of the form, date and sign it, and return it to the DWC Medical Unit. You are required to send a copy of your completed Form 105 to the employer/insurer as well. **If you do not request a panel within ten (10) days of being asked to do so by the employer/insurer, then the employer/insurer has the right to request the panel and choose the medical specialty.** The employer/insurer may not submit Form 105 until ten (10) days have passed after the form was given to the injured worker with the instruction to send the completed form to the DWC Medical Unit.

After you receive the panel list of three QME names, you must select a doctor from the list and make an appointment with the chosen physician. If you do not select a QME from the panel, schedule an appointment with the QME and inform the employer/insurer of the choice **within 10 days of the date the Medical Unit issued the panel**, you may lose the right to choose the QME and the exam date. After the examination is scheduled, you must tell the employer/insurer the time and date of your appointment.

In an unrepresented case, the Medical Unit must issue a panel within twenty working days of its receipt of a request to issue a QME panel, or you may select any QME of your choice to do the evaluation within a reasonable geographic distance from your home. Instructions for completing the form are discussed in the table below.

<i>Field</i>	<i>Instruction</i>	<i>Required or Not</i>
Date of Injury	Insert the date the injury occurred. If this is cumulative trauma injury, insert the last date of exposure of or the last date of work. Use MM/DD/YYYY for the date.	Required
Claim number	This is the number assigned to the claim by the claims administrator.	Required
Specialty requested	Insert the specialty of the QME requested to perform the examination. Use the three letter code from the list attached to form 105.	Required
Requesting party	Check the appropriate box to indicate who is requesting the evaluation.	Required
Reason the QME panel is being requested	Indicate why the examination is being requested. The boxes in this section indicate the part of the Labor Code that describes the types of examinations. An exam to determine whether the injury is work related is a compensability examination under section 4060. An examination to determine the extent of permanent disability is a permanent disability dispute under 4061. Any other type of dispute is under section 4062.	Required
Employee information section	This section asks for the name and address of the injured worker. This is important because panels are created in part based on the location of the injured worker. If the injured worker no longer lives in California or never lived in California there is a section to state the zip code for the panel.	Required
Employer and claims administrator information	This section asks for the name of the employer and the name and address of the claims administrator (insurance company or third-party administrator, for example) and the name of the person handling	Required

<i>Field</i>	<i>Instruction</i>	<i>Required or Not</i>
Signature and date	The requester must sign the form where indicated. Insert the date the form is completed. Use the MM/DD/YYYY format.	Required
Proof of Service	Attached to the form is a proof of service which must be served along with the form. The purpose of the declaration of service is to show the people served with the form. Fill out the proof of service, sign where indicated, and mail to the parties along with the form.	Required

If there is a need to determine if the injury is caused by work, then you must attach the notice sent to the other side requesting an examination to determine whether the injury is the responsibility of workers' compensation or attach a copy of the claim's administrator's notice that the claim was denied. If you are the claims administrator requesting a QME panel to resolve a dispute under Labor Code section 4061 or 4062, you must attach a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical dispute determination that requires a comprehensive medical/legal report to resolve. Examples of what should be attached to the form include an objection of the claims examiner to a determination of the treating physician and requesting the injured worker to request a QME panel.

After you receive the medical evaluation from the QME, you will have the opportunity to ask the evaluator to correct factual errors or omissions in the report under section 37 of the QME rules. Under section 37, you or the claims administrator, or their representative, may use this procedure to have the examiner review facts contained in medical records that were in the examiner's possession at the time of the evaluations that are “capable of verification from written records submitted to a panel QME.” To request a factual correction, you can obtain the form at www.dir.ca.gov/dwc/forms or [contact your local Information and Assistance Office](#).

Finally, remember that whatever forms or documents are sent to the Medical Unit must also be sent to the other side. If you have any questions about completing this form, please [contact the Information and Assistance Officer at your local Division of Workers' Compensation office](#).

Do not file these instructions with your form!