Information & Assistance Unit guide 3

How to object to your summary rating

A summary rating is a document issued by the Disability Evaluation Unit that turns a doctor's report about your injury into a permanent disability rating. Summary ratings are given out after all qualified medical evaluator (QME) exams and after treating doctor exams, when requested. See I&A guide 2 for more information on requesting a QME exam.

Complete this form if you believe your summary rating is wrong. This form can also be completed at http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/DEU/DEU103.pdf.

There are only four reasons to file this request, so follow the instructions carefully. If your reason isn't within one of the four, your request will be denied and your case will be delayed. Disagreeing with the QME or your doctor's conclusion is **not** a reason to object to the summary rating.

You must submit your request within 30 days of receiving the rating.

Along with the form, attach copies of:

1. The summary rating determination
2. The QME or your doctor's report
3. Any other information that supports your request.

Keep a copy of the request for your records and send the original to:

Administrative Director - Division of Workers' Compensation
P. O. Box 420603
San Francisco, CA 94142
Attn: Summary rating reconsideration

You must complete the proof of service at the bottom of the form and you must send a copy to the insurance company.

- ✓ Request for Reconsideration of Summary Rating by the Administrative Director
- ✓ Proof of Service

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

Information & Assistance Unit guide 3

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N PacifiCenter Drive, Suite 170
Information & Assistance Unit **(714) 414-1800**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481 * Satellite office *
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

LONG BEACH, 90802-4339
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 W 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-1653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96002-0940
250 Hemsted Drive, 2nd Fl, Ste. B
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle, Suite 300
Information & Assistance Unit **(916) 928-3158**

SALINAS, 93906-2204
1880 N Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 W Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7014
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA BARBARA, 93101-7538 * Satellite office *
130 E Ortega St.
Information & Assistance Unit **(805) 568-1390**

SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 95202-2314
31 E Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 5/16

DIVISION OF WORKERS' COMPENSATION
REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE ADMINISTRATIVE DIRECTOR

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating issued by the Disability Evaluation Unit should be reconsidered pursuant to Labor Code section 4061(g).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) or Primary Treating Physician (PTP) has failed to address all issues, failed to completely address issues, failed to follow the medical evaluation procedures promulgated by the Administrative Director, or if the rating was incorrectly calculated.
This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
Attn: Summary Rating Reconsideration
P.O. Box 420603
San Francisco, CA 94142

INCLUDE: (1)This completed form;
(2)Other information supporting the request.

Employee

First Name _____ MI _____

Last Name _____

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words) _____

International Address (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer / Adjusting Agency

Name (Please leave blank spaces between numbers, names or words) _____

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Disability Evaluation Unit Case Number

Claim Number

SSN (Numbers Only)

Date of Injury _____
MM/DD/YYYY

REASON(S) FOR REQUEST: (Check reason and explain below. Attach additional sheets if necessary.)

- ☐ QME/PTP failed to address all issues
- ☐ QME/PTP failed to completely address issues
- ☐ Evaluation procedures not followed by QME/PTP
- ☐ Rating was incorrectly calculated

Explanation

Reconsideration of Summary Rating is being requested by:

- ☐ Injured worker
- ☐ Employer/Adjusting Agency

Name

PROOF OF SERVICE BY MAIL (Instructions on next page)

On _____, I served a copy of this Request for Reconsideration of Summary Rating on

Address

City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the Proof of Service By Mail

PROOF OF SERVICE BY MAIL (SAMPLE)

(# 1)

On _____ I served a copy of this Request for Reconsideration of Summary Rating on
MM/DD/YYYY

_____ (# 2)
(name of employee or claims administrator)

_____ (# 3)
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____ (# 4)

1) List on line #1 the date on which you mailed this form.

2) If you are the Injured Employee, list on line #2 the name of the Insurance Carrier or Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee.

3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4.

DIVISION OF WORKERS' COMPENSATION
REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE ADMINISTRATIVE DIRECTOR

SAMPLE

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating issued by the Disability Evaluation Unit should be reconsidered pursuant to Labor Code section 4061(g).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) or Primary Treating Physician (PTP) has failed to address all issues, failed to completely address issues, failed to follow the medical evaluation procedures promulgated by the Administrative Director, or if the rating was incorrectly calculated.
This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
Attn: Summary Rating Reconsideration
P.O. Box 420603
San Francisco, CA 94142

INCLUDE: (1)This completed form;
(2)Other information supporting the request.

Employee

YOUR FIRST NAME
First Name

MI

YOUR LAST NAME
Last Name

YOUR MAILING ADDRESS
Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

YOUR CITY
City

State

Zip Code

Employer / Adjusting Agency

CLAIMS ADMINISTRATOR - USE UNIFORM ASSIGNED NAME
Name (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR ADDRESS
Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR CITY
City

State

Zip Code

EAMS DEU NUMBER

Disability Evaluation Unit Case Number

CLAIM NUMBER

Claim Number

YOUR SSN

SSN (Numbers Only)

Date of Injury DATE OF ACCIDENT

MM/DD/YYYY

REASON(S) FOR REQUEST: (Check reason and explain below. Attach additional sheets if necessary.)

- ☐ QME/PTP failed to address all issues
- ☐ QME/PTP failed to completely address issues
- ☐ Evaluation procedures not followed by QME/PTP
- ☐ Rating was incorrectly calculated

Explanation

LIST REASONS WHY YOU ARE OBJECTING TO THE RATING ISSUED

Reconsideration of Summary Rating is being requested by:

- ☐ Injured worker
- ☐ Employer/Adjusting Agency

Name

PROOF OF SERVICE BY MAIL (Instructions on next page)

On DATE MAILED, I served a copy of this Request for Reconsideration of Summary Rating on

NAME OF CLAIMS ADMINISTRATOR

Address CLAIMS ADMINISTRATOR ADDRESS

CLAIMS ADMINISTRATOR CITY

City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

YOUR SIGNATURE

Signature

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

SAMPLE

Complete the Proof of Service By Mail

PROOF OF SERVICE BY MAIL (SAMPLE)

On (#1) _____ I served a copy of this Request for Reconsideration of Summary Rating on
MM/DD/YYYY

_____ (#2)
(name of employee or claims administrator)

_____ (#3)
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____ (#4)

1) List on line #1 the date on which you mailed this form.

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3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4.