

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 PacificCenter 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

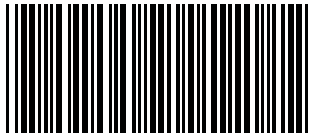
50 "D" Street, Suite 420
Information & Assistance Unit (707) 576-2452

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



**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 _____
MM/DD/YYYY

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

(name of employee or claims administrator)

2

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

3

City

State

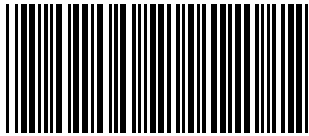
Zip Code

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)

1

On _____
MM/DD/YYYY

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

(name of employee or claims administrator)

2

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

3

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.