

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1
UNREPRESENTED
(Please print or type)

Each form shall be accompanied by an objection to a medical determination made by the treating physician or a notice that there is a need for an examination to determine compensability. Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form.

Date of Injury (Required): _____ Claim Number (Required): _____

Specialty Requested (Required): _____

Requesting party (Required) (Check one box only)

Injured Employee Defense Attorney Claims Administrator

Reason QME panel is being requested (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 or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Daytime Phone No: _____

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: _____

Has the employee ever received a QME panel before? Yes No If yes, Panel Number (if known): _____

Name of QME seen: _____ Date of Exam: _____ Date of Injury: _____

Has that claim been settled or resolved? Yes No Is this a dispute about a current need for medical treatment? Yes No

Employer and Claims Administrator Information (Required)

Employer: _____

Claims Administrator Company Name: _____

Claims Examiner Name: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Phone No: _____

Defendant's Attorney

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 _____

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

QME Form 105 (10/2013) (510) 286-3700 or (800) 794-6900

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On _____, I served this QME 105 form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

- A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
- B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
- C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
- D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
- E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Method of Service	Person or firm served	Street Address
	City:	State Zip Code

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	City	State Zip Code

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ at _____, California.

Type or print name _____

Signature _____

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

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- Internal Medicine
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
MUL — Urology

NON-MD/DO SPECIALTY CODES

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

Do not file this page with your form!