DRAFT

Print Form

Reset Form

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2
REPRESENTED - for injuries occurring prior to January 1, 2005
(Please print or type)

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: _____

Mailing 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 has 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

_____
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

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.

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

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 106 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: _____

Method of Service _____ Person or firm served _____ Street Address : _____

City: _____ State _____ Zip Code: _____

Method of Service _____ Person or firm served _____ Street Address : _____

City: _____ State _____ Zip Code: _____

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 106

MD/DO SPECIALTY CODES

MAA Anesthesiology
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 - Gastroenterology
MMH Internal Medicine-Hematology
MMI Internal Medicine-Infectious Disease
MMO Internal Medicine - Medical Oncology
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
MOQ Medicine Otherwise Qualified
MPO Occupational 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
MUU 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!