DRAFT

MPN RESPONSE TO DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK FORM 9767.17.5 (PART B)

The Medical Provider Network must complete this form

Petitioner's Information

Petitioner's First Name | Petitioner's Last Name | Petitioner's Email Address | Petitioner's Phone

MPN Information

MPN Name | MPN Applicant Name | MPN Approval No.

Date MPN Received Petition

MPN Contact Information

MPN Contact First Name | MPN Contact Last Name | Contact's Email Address | MPN Contact Phone

MPN Authorized Individual Information

First Name | Last Name | Email Address | Phone Number

State reasons why petition should not be granted (additional pages and documents maybe attached):

Verification

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

Executed at _____ (City), California on _____ (Date)

_____ (Name of Authorized Individual) By: _____ (Signature of Authorized Individual)

NOTICE TO MPN

Proof of Service is Required: A proof of service by mail showing a copy of the response has been served on the Petitioner and Administrative Director must be attached and submitted with this form and all supporting documentation within ***30 days*** from the date the petition was served on the MPN.