

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.~~
Identification Number _____

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 _____, California on _____
City Date

By: _____
Name of Authorized Individual 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.