Reset Form

Print Form

DWC Medical Provider Network Complaint Form 9767.16.5

Person filing compliant *(Completion of these fields is required)*

First Name | Last Name | E-mail Address | Phone Number

Mailing Address | City | State | Zip Code

Person filing the complaint is *(Check one)*: ☐ Injured worker ☐ Attorney ☐ Provider ☐ Other

Nature of the Complaint *(Check all that apply and provide sufficient details of the descriptions below)*

☐ Cannot access MPN website provider listing
☐ MPN notice not provided
☐ Unable to contact Medical Access assistant and/ or MPN contact
☐ Physician or specialist not available in the MPN
☐ Inaccurate MPN listing
☐ Other _____

Employer Name | MPN Name | MPN Identification No.

MPN Contact First Name | MPN Contact Last Name | MPN Contact E-mail | MPN Contact Phone

Date of Initial Written Complaint to MPN *(MM/DD/YYYY)*

Imminent Threat to an Injured worker? ☐ Yes ☐ No

Provide a brief description of the complaint *(Attach additional pages as needed)*

1. Describe or state the specific sections of the Labor Code or the MPN regulations violated:

2. State when the violation occurred and whether you believe the violation is still occurring:

3. Describe specifically what attempts you have made with the MPN to address the violation:

4. Describe, what, if any. impact there has been on an injured worker because of the violation:

5. What result are you seeking because of the alleged violation:

Instructions for Formal Complaint Submission to DWC

Serve the MPN Contact listed above with a copy of this completed form and all supporting evidence; and submit this completed form with all supporting evidence and proof of service on the MPN Contact to: *DWC-MPN Complaints, P.O. Box 7101, Oakland, CA 94612*