PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK FORM 9767.17.5

(Print or Type)

NAME OF PETITIONER:_____ PHONE:_____

PETITIONER'S
ADDRESS_____

PETITIONER IS: ____INJURED WORKER ____EMPLOYEE/EMPLOYER REPRESENTATIVE OTHER_____

EMPLOYER (if applicable): _____

EMPLOYER'S ADDRESS:_____

MPN NAME:_____MPN APPROVAL/LOG NO: _____

MPN'S ADDRESS:_____

MPN'S AUTHORIZED INDIVIDUAL: _____PHONE: _____

NAME OF MPN CONTACT:_____MPN CONTACT PHONE: _____

DATE MPN CONTACTED: _____ IMMEDIATE HARM WILL OCCUR? ____ YES ____NO

CHECK BASIS FOR PETITION:

_____THE MPN APPLICANT DOES NOT MEET ELIGIBILITY REQUIREMENTS TO HAVE AN MPN; OR

_____ THE MPN HAS FAILED TO MEET ACCESS STANDARDS FOR COMMONLY USED SPECIALTIES LISTED IN THE APPLICATION IN THE FOLLOWING LOCATIONS AND SPECIALTY(IES) IN THE MPN GEOGRAPHIC SERVICE AREA:

LOCATION:_____SPECIALTY: _____

LOCATION:_____SPECIALTY: _____

LOCATION:_____SPECIALTY: _____

STATE REASONS FOR PETITION (Additional sheets and supporting documentary evidence may be 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: _____
Original Signature of Petitioner Name of Petitioner

_____
Address of Petitioner

YOU MUST ATTACH A PROOF OF SERVICE BY MAIL DECLARATION INDICATING THAT: (1) PART A (PETITION FOR SUSPENSION OR REVOCATION OF MPN) *AND* PART B (RESPONSE TO PETITION FOR SUSPENSION OR REVOCATION OF MPN) OF THIS FORM AND (2) ALL SUPPORTIVE EVIDENCE WERE MAILED TO THE MPN CONTACT AND THE ADMINISTRATIVE DIRECTOR.

Notice to Medical Provider Network:

Pursuant to Title 8, California Code of Regulations, Section 9767.17(d), you may file with the Administrative Director a RESPONSE to this petition within 20 days from the date the petition was served on you. Your Response must be submitted using the *Response to Petition for Suspension or Revocation of MPN* form which is contained in Part B on Pages 3 and 4 of this form. You may attach additional sheets as needed to the Response form.

RESPONSE TO PETITION FOR SUSPENSION OR REVOCATION OF MEDICAL PROVIDER NETWORK FORM 9767.17.5

(***Print or type)***

NAME OF PETITIONER: _____PETITION VERIFICATION DATE_____

MPN NAME:_____ MPN APPROVAL/LOG NO: _____

NAME OF MPN CONTACT:_____ MPN CONTACT PHONE: _____

THE PETITION FOR SUSPENSION OR REVOCATION OF MPN SHOULD NOT BE GRANTED BASED ON THE FOLLOWING: (ADDITIONAL SHEETS AND SUPPORTING DOCUMENTARY EVIDENCE MAY BE 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 _____,_____ ON _____
(City) (State) (Date)

BY: _____//_____
Original Signature of MPN Authorized Individual // Name of Authorized Individual

Address: _____

***NOTICE TO MPN*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE PETITIONER AND THE ADMINISTRATIVE DIRECTOR.**

PROOF OF SERVICE BY MAIL

On _____I served a copy of this Response to Petition for Suspension or Revocation of MPN
(date)
on _____ at _____ and
(Petitioner) *(Petitioner's address)*

the Administrative Director of the Division of Workers' Compensation at _____
(address)

by placing a true copy enclosed in a sealed envelope, addressed as indicated above and with postage fully prepaid, in the U.S. Mail at_____, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____//_____
Original Signature of Declarant // Name of Declarant