DRAFT

DWC MEDICAL PROVIDER NETWORK COMPLAINT FORM 9767.16.5

Person Filing Complaint *(Completion of these fields is required)*

First Name _____ Last Name _____ Email 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)*

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

Employer Name _____ MPN Name _____ MPN ~~Approval~~ **Identification** Number _____

MPN Contact First Name _____ MPN Contact Last Name _____ MPN Contact Email _____ MPN Contact Phone _____

Date of Initial Written Complaint to MPN _____ 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 the alleged violation:

Instructions for Formal Complaint Submission to DWC

1) Serve MPN Contact listed above with a copy of this completed form and all supporting evidence; **and**
2) 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