

**State of California**  
**DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT**  
**REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1**

**UNREPRESENTED**

**(For date of injury on or after 1/1/2013 Please print or type)**

Each form shall be accompanied by an objection to a medical determination made by the treating physician or a notice that there is a need for an examination to determine compensability. Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form.

Date of Injury (Required): \_\_\_\_\_ Claim Number (Required): \_\_\_\_\_

**Specialty Requested (Required):** \_\_\_\_\_

**Requesting party (Required) (Check one box only)**

Injured Employee  Defense Attorney  Claims Administrator

**Reason QME panel is being requested (Check one box only)**

§ 4060 (compensability exam)  § 4061 (permanent disability dispute)  § 4062 (non medical treatment dispute under 4062)

**Employee Information (Required)**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Daytime Phone No: \_\_\_\_\_

If currently not living in state, enter the California zip code on date of injury: \_\_\_\_\_

If never resided in state, enter the California zip code agreed on for the evaluation: \_\_\_\_\_

Has the employee ever received a QME panel before?  Yes  No If yes, Panel Number (If known): \_\_\_\_\_

Name of QME seen: \_\_\_\_\_ Date of Exam: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Has that claim been settled or resolved?  Yes  No Is this a dispute about a current need for medical treatment?  Yes  No

**Employer and Claims Administrator Information (Required)**

Employer: \_\_\_\_\_

Claims Administrator Company Name: \_\_\_\_\_

Claims Examiner Name: \_\_\_\_\_

Street Address or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone No. \_\_\_\_\_

**Defendant's Attorney**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Law Firm Name \_\_\_\_\_

Address/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Date: \_\_\_\_\_ Print Name of Requestor \_\_\_\_\_ Signature of Requestor \_\_\_\_\_

The completed form must be mailed to: Division of Workers' Compensation-Medical Unit- P.O. Box 71010, Oakland, CA 94612  
(510) 286-3700 or (800) 794-6900

**Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form.**

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On \_\_\_\_\_, I served this QME 105 form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

- A     depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.  
placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing.
- B     On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
- C     placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
- D     placing the sealed envelope for pick up by a professional messenger service for service (Messenger must return to you a completed declaration of personal service.)
- E     personally delivering the sealed envelope to the person or firm named below at the address show below.

<u>Method of Service</u>	<u>Person or firm served</u>	<u>Street Address</u>
	<u>City:</u>	<u>State</u> <u>Zip Code</u>

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

Date: \_\_\_\_\_ at \_\_\_\_\_, California.

Type or print name \_\_\_\_\_

Signature \_\_\_\_\_

## For Use with the QME Panel Request Form 105a

### MD/DO SPECIALTY CODES

<u>MAI</u>	<u>Allergy and Immunology</u>
<u>MDE</u>	<u>Dermatology</u>
<u>MEM</u>	<u>Emergency Medicine</u>
<u>MFP</u>	<u>Family Practice</u>
<u>MPM</u>	<u>General Preventive Medicine</u>
<u>MHH</u>	<u>Hand</u>
<u>MMM</u>	<u>Internal Medicine</u>
<u>MMV</u>	<u>Internal Medicine- Cardiovascular Disease</u>
<u>MME</u>	<u>Internal Medicine- Endocrinology Diabetes and Metabolism</u>
<u>MMG</u>	<u>Internal Medicine</u>
<u>MMH</u>	<u>Internal Medicine-Hematology</u>
<u>MMI</u>	<u>Internal Medicine-Infectious Disease</u>
<u>MMN</u>	<u>Internal Medicine-Nephrology</u>
<u>MMP</u>	<u>Internal Medicine-Pulmonary Disease</u>
<u>MMR</u>	<u>Internal Medicine-Rheumatology</u>
<u>MNB</u>	<u>Spine</u>
<u>MPN</u>	<u>Neurology</u>
<u>MNS</u>	<u>Neurological Surgery (other than Spine)</u>
<u>MOG</u>	<u>Obstetrics and Gynecology</u>
<u>MPO</u>	<u>Occupational Medicine</u>
<u>MMO</u>	<u>Oncology- Orthopaedic Surgery Internal Medicine or Radiology</u>
<u>MOP</u>	<u>Ophthalmology</u>
<u>MOS</u>	<u>Orthopaedic Surgery (other than Spine or Hand)</u>
<u>MTO</u>	<u>Otolaryngology</u>
<u>MPA</u>	<u>Pain Medicine</u>
<u>MHA</u>	<u>Pathology</u>
<u>MPR</u>	<u>Physical Medicine &amp; Rehabilitation</u>
<u>MPS</u>	<u>Plastic Surgery (other than Hand)</u>
<u>MPD</u>	<u>Psychiatry (other than Pain Medicine)</u>
<u>MSY</u>	<u>Surgery (other than Spine or Hand)</u>
<u>MSG</u>	<u>Surgery-General Vascular</u>
<u>MTS</u>	<u>Thoracic Surgery</u>
<u>MTT</u>	<u>Toxicology</u>
<u>MUU</u>	<u>Urology</u>

### NON-MD/DO SPECIALTY CODES

<u>ACA</u>	<u>Acupuncture</u>
<u>DCH</u>	<u>Chiropractic</u>
<u>DEN</u>	<u>Dentistry</u>
<u>OPT</u>	<u>Optometry</u>
<u>POD</u>	<u>Podiatry</u>
<u>PSY</u>	<u>Psychology</u>
<u>PSN</u>	<u>Psychology -Clinical Neuropsychology</u>

**Do not file this page with your form!**