**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. |
| B | 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. 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. |

| Method of Service | Person or firm served | Street Address | | |
|---|---|---|---|---|
| | City: | | State | Zip Code |
| Method of Service | Person or firm served | Street Address | | |
| | City | | State | Zip Code |
| Method of Service | Person or firm served | Street Address | | |
| | City | | State | Zip Code |
| Method of Service | Person or firm served | Street Address | | |
| | City | | State | Zip Code |

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 105~~a~~

## *MD/DO SPECIALTY CODES*

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

## *NON-MD/DO SPECIALTY CODES*

| | |
|---|---|
| ACA | Acupuncture |
| DCH | Chiropractic |
| DEN | Dentistry |
| OPT | Optometry |
| POD | Podiatry |
| PSY | Psychology |
| PSN | Psychology -Clinical Neuropsychology |

*Do not file this page with your form!*