Print Form
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State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2
REPRESENTED - for injuries occurring prior to January 1, 2005
(Please print or type)

Date of Injury*(Required):* Claim Number *(Required)*: Specialty of Treating Physician *(Required)*:

Specialty Requested *(Required):* Opposing Party's Specialty Preference *(If known):*

Requesting party *(Required: check one box only)*

☐ Applicant's Attorney ☐ Defense Attorney /Claims Administrator

Reason QME panel is being requested (*Required: 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:

Mailing Address: City: State:

Zip Code: 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:

Answer each question below *(Required)*

Has the employee ever had an AME/QME exam before? ☐ Yes ☐ No

If yes, has that claim been settled or resolved? ☐ Yes ☐ No

Is this a dispute about a current need for medical treatment? ☐ Yes ☐ No

Is this a dispute over an additional body part ? ☐ Yes ☐ No

If the employee has seen an AME/ QME for this injury, provide the information below:

Name of AME/QME seen:

Date of Exam:

Name of the Primary Treating Physician: Date of Report being objected to:

Describe the nature of the dispute that requires resolution:

Employee's Attorney (*Required)*

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

(Continue form on next page)

Claim Number: _____

Employer and Claims Administrator Information

Employer: _____

Claims Administrator Company Name: _____

Claims Adjustor Name: _____

Street Address or P.O. Box: _____

City: _____ State: ____ Zip Code: _____ Phone Number: _____

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

Note: The party submitting this form must attach a copy of the written objection to an opinion of a treating physician identifying an issue in dispute.

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

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 106 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 shown below.

Method of Service _____ Person or firm served _____ Street Address : _____

City: _____ State _____ Zip Code: _____

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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 106

MD/DO SPECIALTY CODES

MAA	Anesthesiology
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 - Gastroenterology
MMH	Internal Medicine - Hematology
MMI	Internal Medicine - Infectious Disease
MMO	Internal Medicine - Medical Oncology
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
MOQ	Medicine Otherwise Qualified
MPO	Occupational Medicine
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

Do not file this page with your form!