

State of California, Division of Workers' Compensation
REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUATOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. Complete this form (print or type the information). Sign and date at bottom.
2. If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.
3. Complete the attached Proof of Service.
4. For Employee: Mail the completed signed form and Proof of Service to:
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900
5. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.
6. For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

Panel Request Information :

Date of Injury: _____ Claim Number: _____ Specialty Requested: _____

(Select only ONE specialty)

Requesting Party: ☐ Employee ☐ Claims Administrator ☐ Defense Attorney

Reason for QME Panel Request (check one):

- ☐ To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).
- ☐ Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.
- ☐ Work injury claim is accepted for one or more body parts, there is a dispute over additional body parts.
- ☐ Other (specify non-medical treatment dispute): _____

Employee Information

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address or P.O. Box: _____

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: _____

Employer/Claims Administrator Information

Employer: _____ Zip Code of Employer: _____

Claims Administrator Company Name: _____ Adjuster/Contact Name (if known): _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Requestor Signature: _____ Date: _____

PROOF OF SERVICE

Instructions:

1. Complete the Proof of Service.
2. For Employee: Mail the completed signed form and Proof of Service to:
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900
3. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.
4. For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

I declare that I am a resident of or employed in the county of _____, California; I am over the age of eighteen years.

On _____, I served the attached completed Form 105 on the following parties:

☐

by mail to:

Name of Employee or Claims Administrator

Street Address

City, State, Zip code

☐

by hand-delivery to:

Name

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.

Executed on _____, at _____, California

Type or Print Name: _____

Signature: _____

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAA	Anesthesiology	MHH	Orthopedic Surgery - Hand
MAI	Allergy & Immunology	MTO	Otolaryngology
MPA	Pain Medicine	MHA	Pathology
MDE	Dermatology	MPR	Physical Medicine & Rehabilitation
MAI	Dermatology – Allergy & Immunology	MPA	Physical Medicine & Rehabilitation – Pain Medicine
MEM	Emergency Medicine	MPS	Plastic Surgery (other than Hand)
MTT	Emergency Medicine – Toxicology	MHH	Plastic Surgery – Hand
MFP	Family Practice	MPD	Psychiatry (other than Pain Medicine)
MPM	General Preventive Medicine	MPA	Psychiatry – Pain Medicine
MTT	General Preventive Medicine – Toxicology	MSY	Surgery (other than Spine or Hand)
MMM	Internal Medicine	MHH	Surgery - Hand
MAI	Internal Medicine- Allergy & Immunology	MSG	Surgery- General Vascular
MMV	Internal Medicine – Cardiovascular Disease	MTS	Thoracic Surgery
MME	Internal Medicine - Endocrinology Diabetes & Metabolism	MUU	Urology
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		
MPN	Neurology		
MPA	Neurology – Pain Medicine		
MNS	Neurological Surgery (other than Spine)		
MNB	Neurological Surgery – Spine		
MOG	Obstetrics & Gynecology		
MOQ	Medicine Otherwise Qualified		
MPO	Occupational Medicine		
MTT	Occupational Medicine – Toxicology		
MOP	Ophthalmology		
MOS	Orthopedic Surgery (other than Spine or Hand)		
MNB	Orthopedic Surgery - Spine		

NON-MD/DO SPECIALTIES CODES

ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology

Do not file this page with your form!