Print Form
Reset Form

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

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, 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 shown below.

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

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- Internal 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
PSN	Psychology -Clinical Neuropsychology

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HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR
IF YOU DO NOT HAVE AN ATTORNEY
(Attachment to Form 105)

The purpose of a Qualified Medical Evaluator (QME) examination is to obtain a second medical opinion to help resolve disputed medical issues in your workers' compensation claim(s). If you are an injured worker who is not represented by an attorney, use QME Form 105 to obtain a panel of three QMEs, one of which will examine you in the event there is a disagreement over some of the opinions of your treating physician or there is a need to determine if the claimed injury is work related. The QME report must discuss all of the disputed and unresolved issues in your claim that need a medical opinion.

An injured worker has the first opportunity to choose the type of physician to perform the exam. If you are an injured worker requesting a QME panel, write the medical specialty you prefer for the QME where indicated, complete the rest of the form, date and sign it, and return it to the DWC Medical Unit. You are required to send a copy of your completed Form 105 to the employer/insurer as well. **If you do not request a panel within ten (10) days of being asked to do so by the employer/insurer, then the employer/insurer has the right to request the panel and choose the medical specialty.** The employer/insurer may not submit Form 105 until ten (10) days have passed after the form was given to the injured worker with the instruction to send the completed form to the DWC Medical Unit.

After you receive the panel list of three QME names, you must select a doctor from the list and make an appointment with the chosen physician. If you do not select a QME from the panel, schedule an appointment with the QME and inform the employer/insurer of the choice **within 10 days of the date the Medical Unit issued the panel**, you may lose the right to choose the QME and the exam date. After the examination is scheduled, you must tell the employer/insurer the time and date of your appointment.

In an unrepresented case, the Medical Unit must issue a panel within fifteen working days of its receipt of a request to issue a QME panel, or you may select any QME of your choice to do the evaluation within a reasonable geographic distance from your home. Instructions for completing the form are discussed in the table below.

Field	*Instruction*	*Required or Not*
Date of Injury	Insert the date the injury occurred. If this is cumulative trauma injury, insert the last date of exposure of or the last date of work. Use MM/DD/YYYY for the date.	Required
Claim number	This is the number assigned to the claim by the claims administrator.	Required
Specialty requested	Insert the specialty of the QME requested to perform the examination. Use the three letter code from the list attached to form 105.	Required
Requesting party	Check the appropriate box to indicate who is requesting the evaluation.	Required
Reason the QME panel is being requested	Indicate why the examination is being requested. The boxes in this section indicate the part of the Labor Code that describes the types of examinations. An exam to determine whether the injury is work related is a compensability examination under section 4060. An examination to determine the extent of permanent disability is a permanent disability dispute under 4061. Any other type of dispute is under section 4062.	Required
Employee information section	This section asks for the name and address of the injured worker. This is important because panels are created in part based on the location of the injured worker. If the injured worker no longer lives in California or never lived in California there is a section to state the zip code for the panel. There is a question about whether the injured worker has been seen by a QME before; this is a yes or no question. If the answer to that question is yes, then there are additional questions about that examination to be answered.	Depends on the circumstances
Employer and claims administrator information	This section asks for the name of the employer and the name and address of the claims administrator (insurance company or third-party administrator, for example) and the name of the person handling	Required

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Field	*Instruction*	*Required or Not*
Defense attorney information	Sometimes there is a defense attorney who is representing the defendant. If there is a defense attorney assigned to the claim insert the first and last name of the attorney, the name, address and phone number of the attorney's law firm.	Not Required
Date, name of the requestor and signature	Insert the date the form is completed. Use the MM/DD/YYYY format. Print the name of the person requesting the QME panel. The requestor must sign the form where indicated.	Required
Declaration of Service	Attached to the form is a declaration of service which must be served along with the form. The purpose of the declaration of service is to show the people served with the form. Fill out the declaration of service, sign where indicated, and mail to the parties along with the form.	Required

If you are requesting a QME panel, you must attach a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical dispute determination that requires a comprehensive medical/legal report to resolve, or you may attach a request for an examination to determine the compensability under Labor Code section 4060. Examples of what should be attached to the form include the injured worker's objection to a permanent disability determination made by the primary treating physician, or an objection of the claims examiner to a determination of the treating physician and requesting the injured worker to request a QME panel. If there is a need to determine if the injury is caused by work, the you must attach the notice sent to the other side requesting an examination to determine whether the injury is the responsibility of workers' compensation.

After you receive the medical evaluation from the QME, you will have the opportunity to ask the evaluator to correct factual errors or omissions in the report under section 37 of the QME rules. Under section 37, you or the claims administrator, or their representative, may use this procedure to have the examiner review facts contained in medical records that were in the examiner's possession at the time of the evaluations that are “capable of verification from written records submitted to a panel QME.” To request a factual correction, visit the forms section of the DWC website or contact your local Information and Assistance Office.

Finally, remember that whatever forms or documents are sent to the Medical Unit must also be sent to the other side. If you have any questions about completing this form, please contact the Information and Assistance Officer at your local Division of Workers' Compensation office.

Do not file these instructions with your form!