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
(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: _____

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 106

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
In a represented case
(Attachment to Form 106)

Note: Use QME Form 106 only in cases in which the injured employee is represented by an attorney. If you are not represented by an attorney, please use Form 105.
To request a panel of three QMEs in a represented case, one of the parties to the case first must notify the opposing party or parties of either (1) the need for a medical evaluation to resolve a compensability dispute pursuant to Labor Code section 4060 or (2) that the notifying party is objecting to a medical determination made by the primary treating physician under Labor Code section 4061 or 4062. Once such notification is made , the parties must wait 10 days, plus 5 days if the notification was mailed. Once the waiting period has passed, either party may request a panel on QME Form 106. A copy of the panel request must be served on the other party.

After the panel has been issued, each party may strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator. If a party fails to exercise the right to strike a name from the panel within 10 days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator. Once the striking process has been completed, the injured worker is responsible for arranging the appointment for the examination and informing the defendant within 10 days after the medical evaluator has been selected. If the employer is not informed of the appointment date, the employer may make the appointment. (Lab. Code § 4062.2 (d).) 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 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. There is also a claim number field on page two.	Required
Specialty of treating physician	Insert the specialty of the injured worker's treating physician. Use the three letter code from the list attached to form 106, if possible.	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 106.	Required
Opposing party's specialty preference	Insert the QME specialty preference of the opposing party. Use the three letter code from the list attached to form 106.	Not required
Requesting party	Check the appropriate box to indicate who is requesting the evaluation, applicant's attorney or defense attorney or the claims administrator.	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. There are also required questions about the current dispute leading to the QME request, including a description of the dispute.	Depends on the circumstances
Employee attorney information	This section asks for the name and address of the employee's attorney, and the name, address, and telephone number of the attorney's law firm. The UAN information for the law firm may be used	Required

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Field	Instruction	Required or Not
Employee 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 the claim.	Required
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 of the attorney's law firm and the address and phone number for the attorney.	Not Required
Date, name of the requestor and signature	Insert the date the form is completed. Use the MM/MM/YYYY format. Print the name of the person requesting the QME panel and the requestor must sign the request.	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

The person requesting the panel 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 attach a request for an examination to determine the compensability under Labor Code section 4060. Examples of what could be attached to the form include an objection to a permanent disability determination made by the primary treating physician, or an objection by the claims examiner to a determination of the treating physician requesting the injured worker to request a QME.

If you have any questions about completing this form, please contact the Medical Unit of the Division of Workers' Compensation at 800-794-6900.

Do not file these instructions with your form!