

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

Request date (Required): 8-14-11 Date of Injury (Required): 6-29-11 Claim Number (Required): VE 90000198

Specialty Requested (Required):

DCH
(use 3 letter code only)

Requesting party (Check one box only):

- Unrepresented Injured Employee
 Claims Administrator, if none, Employer
 Defense Attorney

Reason QME panel is being requested (Check one box only):

- § 4060 (compensability exam)
 § 4061 (permanent impairment or disability dispute)
 § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)
 § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
 §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

Answer each question below:

Has this claim been denied? Yes No Has any body part in this claim been accepted? Yes No

If yes, indicate the date of the denial _____

Did notice to injured employee state employer requests an evaluation to determine compensability?(Attach copy of notice) Yes No

Does dispute involve an MPN : Continuity or Transfer of Care Permanent Disability, Future Medical, UR decision Diagnosis/Treatment ?

Employee Information

First Name: Tiffany Middle Initial: K Last Name: Anderson

Street Address : 2 N. Avena Avenue

City: Lodi State: CA Zip Code: 95240 Daytime Phone No: 209-329-9523

If you now live out of state, list the California city and zip code of your residence when injured: NA

If you never resided in California, list the California zip code in which you would like to be evaluated: NA

Employer and Claims Administrator Information

Employer: San Joaquin County Mosquito & Vector Control District

Claims Administrator Name: AIMS

Adjustor name: Mackenzie Dawson

Street Address or P.O. Box: P.O. Box 269120

City: Sacramento State: CA Zip Code: 95826 Phone No. 916-563-1900

Claim Number: VE90000198

Prior QME Panel Information (Answer all that apply)

Has the employee ever received a QME panel before? Yes No Unknown
If yes, did the employee ever see any QME from that panel? Yes No Unknown
If yes, has that claim been settled or resolved? Yes No Unknown

If yes, name of QME seen: Khosrow, Tabaddor Specialty: Orthopedic Surgeon

Date of Injury: 6-19-2008 7-2-2009 Body parts: Right Knee Date of Exam: 6-15-10

Panel Number (if known): 86351-0 Is that QME available now: Yes No Unknown

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

Date: 8-14-11
Tiffany Kay Anderson
Print Name of Requestor

[Signature]
Signature of Injured Employee

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