

DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation Medical Unit
P.O. Box 71010
Oakland, CA 94612
Tel: (510) 286-3700 or (800) 794-6900



March 15, 2023

TO: [REDACTED]
SEDGWICK CMS
P O BOX 14522
LEXINGTON, KY 40512

Ref no: [REDACTED]
ER: COUNTY OF VENTURA
DOI: 12/18/2022
Claim #: [REDACTED]

The Medical Unit is unable to fulfill your panel request for the reason(s) listed below.

1. We are unable to assign a panel of three Qualified Medical Evaluators (QMEs) because we currently do not have sufficient QMEs listed in the medical specialty you requested. Use the attached medical specialty list to select a different medical specialty.

If this request needs to be returned, please resubmit a copy of this rejection letter with your completed panel request and documentation to:

Department of Industrial Relations
Division of Workers Compensation Medical Unit
PO Box 71010
Oakland, CA 94612

**Request must be sent by US Mail only.
Faxed requests will not be accepted.**

CC: [REDACTED]
[REDACTED]
[REDACTED]

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAA Anesthesiology
MAI Allergy & Immunology
MPA Pain Medicine
MDE Dermatology
MAI Dermatology – Allergy & Immunology
~~MTT Emergency Medicine~~
MTT Emergency Medicine – Toxicology
MFP Family Practice
~~MTT General Preventive Medicine~~
MTT General Preventive Medicine – Toxicology
MMM Internal Medicine
MAI Internal Medicine- Allergy & Immunology
MMV Internal Medicine – Cardiovascular Disease
~~MMG Internal Medicine – Endocrinology, Diabetes, & 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
MPN Neurology
MPA Neurology – Pain Medicine
MNS Neurological Surgery (other than Spine)
MNB Neurological Surgery – Spine
~~MOG Obstetrics & Gynecology~~
~~MOQ Medicine, Osteopathic Qualified~~
MPO Occupational Medicine
MTT Occupational Medicine – Toxicology
MOP Ophthalmology
MOS Orthopedic Surgery (other than Spine or Hand)
MNB Orthopedic Surgery - Spine

MHH Orthopedic Surgery - Hand
MTO Otolaryngology
~~MTH Pathology~~
MPR Physical Medicine & Rehabilitation
MPA Physical Medicine & Rehabilitation – Pain Medicine
MPS Plastic Surgery (other than Hand)
MHH Plastic Surgery – Hand
MPD Psychiatry (other than Pain Medicine)
MPA Psychiatry – Pain Medicine
MSY Surgery (other than Spine or Hand)
MHH Surgery - Hand
MSG Surgery- General Vascular
~~MTS Thoracic Surgery~~
MUU Urology

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!

DEPARTMENT OF INDUSTRIAL RELATIONS
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P.O. Box 71010
Oakland, CA 94612
Tel: (510) 286-3700 or (800) 794-6900



March 21, 2023

TO: [REDACTED]

Ref no: [REDACTED]

ER: COUNTY OF VENTURA

DOI: 12/18/2023

Claim #: [REDACTED]

The Medical Unit is unable to fulfill your panel request for the reason(s) listed below.

1. Your request has the following missing information:
 - a. Date of injury is not given, incorrect or incomplete
2. To obtain a QME panel to determine if the injury is work-related you must attach the claims administrator's notice that the claim was denied or a copy of the claims administrator's request for an evaluation.
3. Please verify DOI. **If you need help resubmitting your request for a panel contact either your claims examiner or an Information and Assistance office nearest you. Attached is a list of Information and Assistance offices.**

If this request needs to be returned, please resubmit a copy of this rejection letter with your completed panel request and documentation to:

Department of Industrial Relations
Division of Workers Compensation Medical Unit
PO Box 71010
Oakland, CA 94612

**Request must be sent by US Mail only.
Faxed requests will not be accepted.**

CC: [REDACTED]

SEDGWICK 14522 VAN NUYS
PO BOX 14522
LEXINGTON, KY 40512

**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) 784-5900
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: 12/18/2023 Claim Number: [REDACTED] Specialty Requested: MMG
(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 *Missing Notice* or a copy of the claims administrator's request for an evaluation *Delayed*).
- 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: [REDACTED] Middle Initial: [REDACTED] Last Name: [REDACTED]

Street Address or P.O. Box: 3530 Heather Glen

City: Thousand Oaks State: CA Zip Code: 91320

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: _____

**RECEIVED
MAR 14 2023
DIR/DWC/MEDICAL UNIT**

Employer/Claims Administrator Information

Employer: County of Ventura Zip Code of Employer: 93009

Claims Administrator Company Name: Sedgwick Claims Management Services Inc. Adjuster/Contact Name (if known): [REDACTED]

Street Address or P.O. Box: P.O. Box 14522

City: Lexington State: KY Zip Code: 40512 Phone No.: 805-280-4070

Requestor Signature: [REDACTED] Date: 3/10/2023

1e, #17, #22 - please verify DOI.

*W
03/15/23*

2/27/2023

[REDACTED]

[REDACTED]

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 Ventura, California; I am over the age of eighteen years.

On 3/10/2023, I served the attached completed Form 105 on the following parties:



by mail to:

Sedgwick Claims Management Services Inc.
 Name of Employee or Claims Administrator
P.O. Box 14522
 Street Address
Lexington, KY, 40512 ✓
 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 3/10/2023 at Ventura, California

Type or Print Name: [Redacted]

Signature: [Redacted] ✓