



PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

10/01/2020

Division of Workers' Compensation – Medical Unit
Post Office Box 71010
Oakland, CA 94612

Important documents enclosed for your review.

Division of Workers' Compensation – Medical Unit,

The following document regarding claim CWC230230896 is enclosed for your review and action as appropriate:

- Claim Correspondence

We are committed to providing the best service possible. If you have any questions, our qualified service representatives are waiting to assist you at 888-266-7937.

Thank you for your continued partnership.

Claims Department
CompWest Insurance Company

cc: Angel Hernandez
22113 Grand Terrace Road Space 7
Grand Terrace, CA 92313



PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

10/01/2020

Division of Workers' Compensation – Medical Unit
Post Office Box 71010
Oakland, CA 94612

Re: Claim #: CWC230230896
Policyholder: M4 MANAGEMENT INC
Injured Worker: Angel Hernandez
Date of Injury: 10/03/2019
Date of Birth: 08/23/1952
Underwritten by: CompWest Insurance Company

Dear Division of Workers' Compensation – Medical Unit:

Please process request for panel enclosed herein. Thanks

If you have any questions, please contact me at 888-266-7937.

Sincerely,

Oscar Vasquez
Claims Representative II
Oscar.Vasquez@compwestinsurance.com
888-266-7937

Enclosure(s)

Angel Hernandez
22113 Grand Terrace Road Space 7
Grand Terrace CA 92313

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 – Cardiolvascular 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!



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CompWestInsurance.com

09/10/2020

Angel Hernandez
22113 Grand Terrace Road
Space 7
Grand Terrace, CA 92313

Important documents enclosed for your review.

Angel Hernandez,

The following document regarding claim CWC230230896 is enclosed for your review and action as appropriate:

- Letter Objecting to the Treating Doctor's Determination

We are committed to providing the best service possible. If you have any questions, our qualified service representatives are waiting to assist you at 888-266-7937.

Thank you for your continued partnership.

Claims Department
CompWest Insurance Company

cc: Arrowhead Orthopedics
1901 W Lugonia Ave Ste 120
Redlands, CA 92374



PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

09/10/2020

Angel Hernandez
22113 Grand Terrace Road Space 7
Grand Terrace, CA 92313

Re: Claim #: CWC230230896
Policyholder: M4 MANAGEMENT INC
Injured Worker: Angel Hernandez
Date of Injury: 10/03/2019
Underwritten by: CompWest Insurance Company

You may lose important rights if you do not take certain actions within 10 days.

Dear Angel Hernandez:

I am responsible for handling your workers' compensation claim on behalf of M4 MANAGEMENT INC. This letter is to notify you that we do not agree with the opinion of Dr. Andrew S. Wong, M.D. with regards to your medical condition in his/her report dated 08/31/2020.

Pursuant to *Labor Code Sections 4061 and 4062*, we are letting you know that we do not agree and you should request a Panel Qualified Medical Evaluation (PQME). *Labor Code 4061* means that If either one of us disagrees with the treating doctors opinion, we can get an independent evaluation and send it to the Division of Workers' Compensation. The Division will then send you three doctors to choose from for the evaluation.

The PQME will determine the following issues:

1. Future medical treatment
2. Maximum Medical Improvement determination
3. Permanent Disability determination

§ 4062 claims administrator only (non-treatment medical determination or non-UR reason under 4062)

A **§ 4062** panel request means either party can request an independent evaluation for certain medical issues; specifically Maximum Medical Improvement (MMI), work status and future medical care. The reason for this request is:

- Address whether Angel Hernandez's medical condition has reached MMI (Maximum Medical Improvement) status
- Other:



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I have enclosed a form for you to request a panel of physicians appointed by the State. The form should be completed and sent to the Division of Workers' Compensation within the next 10 days. If I do not hear from you 10 days from receipt of this letter, I will proceed to submit the form to the State myself and request a panel for you.

The State will then send you a list of doctors to pick from. You must schedule the appointment and let me know the date of the appointment within 10 days of the issuance of the panel. If you do not notify me within 10 days, I will choose a physician from the panel list and schedule an appointment for you.

If you have any questions, please contact me at 888-266-7937.

Sincerely,

Oscar Vasquez
Claims Representative II
Oscar.Vasquez@compwestinsurance.com
888-266-7937

Enclosure: Request for Panel QME (QME Form 105)



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CompWestInsurance.com

10/01/2020

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Post Office Box 71010
Oakland, CA 94612

Important documents enclosed for your review.

Division of Workers' Compensation – Medical Unit,

The following document regarding claim CWC230230896 is enclosed for your review and action as appropriate:

- Proof of Service

We are committed to providing the best service possible. If you have any questions, our qualified service representatives are waiting to assist you at 888-266-7937.

Thank you for your continued partnership.

Claims Department
CompWest Insurance Company

cc: Angel Hernandez
22113 Grand Terrace Road Space 7
Grand Terrace, CA 92313



PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

Uniform Assigned Name: COMPWEST NEWPORT BEACH
EAMS Administrator Name: Grace Hastings
EAMS Administrator's Phone: 714-641-9580
EAMS Administrator's Email: ghastings@compwestinsurance.com

DECLARATION OF SERVICE BY MAIL
M4 MANAGEMENT INC v. Angel Hernandez
CASE NO:
CLAIM NO: CWC230230896

I, Oscar Vasquez, declare: that I am, and was at the time of service of the papers herein referred to, over the age of eighteen years, and not a party to the action; and I am employed in the County of Orange, California. My business address is PO Box 40790 Lansing, MI 48901-7990. I serve the following document[s]

- Proof of Service

by placing a copy thereof in a separate envelope for each addressee named hereinafter, addressed to each such addressee respectfully as follows:

SERVICE LIST ATTACHED

By Mail:

As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. Postal Service on that same day with postage herein fully prepaid at Lansing, MI in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. Executed at Santa Ana, CA, on 10/01/2020.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 10/01/2020

Oscar Vasquez

Signature



PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

SERVICE LIST:

Division of Workers' Compensation – Medical Unit
Post Office Box 71010
Oakland CA 94612

Angel Hernandez
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