## **Employee Section:** The Employee shall complete this section and send the completed form to the Administrative Director. Mailing address: Dept. of Industrial Relations, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612.

Employee Name		Employee Phone Number / Fax	Employee's Address		
Employee's Attorney's Name	e, if applicable	Attorney's Phone Number / Fax	Attorney's Address		
Pursuant to Labor Code within 30 days from rece			tive Director set an Independent Medical Review		
Check one:	t for In-Person	Examination	ecord Review (no In-Person Examination)		
Is interpreter needed for ex	.am? I	f yes, language:			
Describe diagnosis and par	t of body affect	ed:			
		al Review. Please explain if the ials, such as medical records, if	dispute involves the diagnosis, treatment or a test necessary):		
Select an alternative specia	alty, other than s	specialty of treating physician, if	f any, from the list on the instructions for this form:		
Release: I,		(injured	employee or person authorized pursuant to law to act on		
behalf of the injured emplo	oyee), authorize	the release of relevant medical n	records to the Independent Medical Reviewer.		
Signature of injured employe	e or authorized po	erson	Date		
Medical Provider Netwo	k Contact Sec	tion: The MPN Contact shall co	mplete this section and send the form to the employee.		
Employee		Employer	Employer		
Insurer		Claim Number	Claim Number		
Medical Provider Network		Date of Injury	Date of Injury		
Treating Physician		Specialty	Address		
2nd Opinion Physician and specialty		3 <sup>rd</sup> Opinion Physic	ian and specialty		
Select an alternative specia	alty other than s	pecialty of treating physician, if	any, from the list on the back of this form:		
I declare under penalty of	perjury that I ma	ailed a copy of the Application f	for IMR to the above named Employee on:		
Date Si	gnature	Phone nun	nber, fax, and email of MPN Contact		
Name of MPN Contact	A	ddress			
DWC Form 9768.10		1			

## **Instructions for Independent Medical Review Application Form**

**Instructions for MPN Contact:** At the time of the selection of the physician for a third opinion, you are required to notify the covered employee about the Independent Medical Review process and provide the covered employee with this "Independent Medical Review Application" form. You are required to fill out the "MPN Contact section" of the form. You must then send the form to the employee, who will fill out the top section of the form and send it to the Division of Workers' Compensation. The DWC will send you written notification of the name and contact information of the Independent Medical Reviewer. You must then send the employee's relevant medical records as defined by section 9768.1(a)(11) to the Independent Medical Reviewer. A copy of the medical reports must also be sent to the employee.

**Instructions for Injured Employee:** This application is being sent to you because you have requested a third opinion to address your dispute with your treating doctor's diagnosis, suggested test, or suggested medical treatment. **Please wait until you read the report from the third opinion doctor before you fill out this form.** If the report resolves your dispute, then you do not need to fill out this form. If you still have a dispute with your treating doctor, then you may request an Independent Medical Review by completing this form and sending it to:

Dept. of Industrial Relations Division of Workers' Compensation P.O. Box 71010 Oakland, CA 94612.

An Independent Medical Review is done by a physician who does not work directly with your doctor. You can visit that doctor and be examined or you can choose to have the doctor review your records. Indicate on the form whether you want to be examined (in-person examination) or if you only want to have your records reviewed.

The specialty of the doctor will be the same as the specialty of your treating physician, if possible. Not all types of doctors can be an Independent Medical Reviewer. You may select another type of doctor in case your doctor's specialty is not available. To do this, look at the list of specialists below and chose one type. Indicate this choice on the application. You will receive the name and contact information of the Independent Medical Reviewer from the Division of Workers' Compensation. When you receive the name of the Independent Medical Reviewer, you must make an appointment within 60 days. The Independent Medical Reviewer is required to schedule an appointment with you within 30 days. If you fail to make the appointment with the Independent Medical Reviewer is made to the Administrative Director and MPN Contact if you wish to withdraw the request for an Independent Medical Review after this form has been submitted.

	SI ECIALI I CODES		
MAI	Allergy and Immunology	MAA	Anesthesiology
MRS	Colon & Rectal Surgery	MDE	Dermatology
MEM	Emergency Medicine	MFP	Family Practice
MPM	General Preventive Medicine	MHD	Hand – Orthopaedic Surgery, Plastic Surgery, General
			Surgery
MMM	Internal Medicine	MMV	Internal Medicine – Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes and	MMG	Internal Medicine - Gastroenterology
	Metabolism		
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	MNS	Neurological Surgery
MNM	Nuclear Medicine	MOG	Obstetrics and Gynecology
MPO	Occupational Medicine	MOP	Ophthalmology
MOS	Orthopaedic Surgery	MTO	Otolaryngology
MAP	Pain Management – Psychiatry and Neurology,	MHA	Pathology
	Physical Medicine and Rehabilitation, Anesthesiology		
MEP	Pediatrics	MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery	MPD	Psychiatry
MRD	Radiology	MSY	Surgery
MSG	Surgery – General Vascular	MTS	Thoracic Surgery
MTX	Toxicology – Preventive Medicine, Pediatrics,	MUU	Urology
	Emergency		
POD	Podiatry		

SPECIALTY CODES