

Second or Third Opinion Request Form

If you dispute the diagnosis or treatment prescribed by your treating physician or the diagnosis or treatment prescribed by the second opinion physician, complete this form and return it to your claims adjustor at the address indicated below.

On receipt of this completed form the claims adjustor will provide you a list of the available medical provider networks physicians based on the specialty and recognized expertise needed in treating your injury. You are to select a physician or specialist from this list. It is your obligation to make an appointment with the selected physician and then advise your claims adjustor so they may prepare appropriate copies of medical records and furnish them to the chosen specialist prior to the examination date.

If the appointment is not made within 60 days of receipt of the list of available medical provider network physicians you are deemed to have waived your right to the second or third opinion process with regard to the disputed diagnosis or treatment of your treating physician.

I DISPUTE THE DIAGNOSIS AND/OR MEDICAL TREATMENT OF THE TREATING PHYSICIAN OR THE SECOND OPINION PHYSICIAN.

Employee Name

Employee Address

Social Security Number

Employee Phone Number

Signature

Date

NATURE OF DISPUTE

Describe the disputed diagnosis and/or the disputed medical treatment:

Return this Completed Form to:

Workers' Compensation Services
1115 Truxtun Ave., 4th Fl.
Bakersfield, CA 93301