State of California
Department of Industrial Relations
Division of Workers' Compensation

OBJECTION TO TREATING PHYSICIAN'S RECOMMENDATION FOR SPINAL SURGERY

EMPLOYEE

Last Name	First Name	Other names/initials	Social Security Number	Date of Injury

W.C.A.B. Case No.	Claim No. (If Available)	Telephone (If Available)	Fax No. (If Available)

RESIDENCE ADDRESS: Street	City	State	Zip Code

EMPLOYER

Name

MAILING ADDRESS: Street	City	State	Zip Code

Insurance Carrier:

Claims Administrator:

Company providing utilization review:

Employer health care provider:

EMPLOYEE'S ATTORNEY

Name

MAILING ADDRESS: Street	City	State	Zip Code

Telephone:	Fax Number:

TREATING PHYSICIAN

Last Name:	First Name:	Other names/initials:

MAILING ADDRESS: Street	City	State	Zip Code

Telephone:	Fax Number:	E-mail:

Physician's Medical Group:

Independent Practice Association:

Exact procedure which is being objected to:

Name of facility or institution at which the proposed procedure is to be performed:

Name of facility or institution at which an alternative procedure (if any) recommended by the employer, employer health care provider, carrier, or administrator is proposed to be performed:

Date that the treating physician's recommendation for this procedure was first received by any of employer, insurance carrier, administrator:

Name of entity which received it on that date:

Type of entity (employer, insurance carrier, or administrator):

NAME OF PERSON SIGNING THIS OBJECTION:

Name:	Company:		
MAILING ADDRESS: Street	City	State	Zip Code
Telephone:	Fax Number:	E-mail:	

Reason(s) for this objection, specific to this employee:

Declaration Regarding Receipt of Report – SEE INSTRUCTIONS

Version A

I declare under penalty of perjury of the laws of the State of California that:

1. I am employed by _____.
2. The enclosed physician's report was first received by the employer, insurance carrier or administrator, the name of which firm is _____, on _____.
(date)
3. I have personal knowledge of the above facts.

_____ _____

(Signature of Declarant) (date)

Version B

I declare under penalty of perjury of the laws of the State of California that:

1. I am employed by _____.
2. The enclosed physician's report was first received by the employer, insurance carrier or administrator, the name of which firm is _____, on _____.
(date)
3. The firm stated in (2), above, has a written policy of date-stamping every piece of mail on the date it is delivered to its office; this policy is consistently followed; I am knowledgeable about this policy, and the report bears a date stamp showing that it was received in the firm's office on _____.
(date)

I have personal knowledge of the facts in (1) and (3), above, and as to the facts in (2), above, I am informed and believe them to be true.

_____ _____

(Signature of Declarant) (date)

_____ _____ _____

(Signature of Person Executing Form) **(Title)** **(date)**

Declaration Regarding Service of Objection

I declare under penalty of perjury of the laws of the State of California that:

1. I am employed by _____.

2. On _____, I served the enclosed objection on the persons/firms served,
(date)

and on the Administrative Director, and by the means of service, indicated in the box below. If service is by mail, I further declare that I am readily familiar with the practice of the office stated in (1), above, of collection and processing of correspondence for mailing. Under that practice it would be deposited with the U.S. Postal Service on that same day with postage fully prepaid at _____ California, in the ordinary course of business. I further declare that if served by mail, I either deposited the objection personally in the U.S. Mails, or that I placed it for normal collection with the office stated in (1), in time for collection and processing that same day. If service is by fax, I further declare that I transmitted a true copy to the fax numbers stated in the box below pursuant to oral and/or written agreement by the recipient to receive by fax. If service is by delivery, I further declare that I am familiar with the practice of the office stated in (1), above for messenger delivery, and I caused the objection in a sealed envelope to be delivered to a courier employed by _____ who was to personally deliver each such envelope within two working days to the office of the address at the place and on the date indicated in the box below:

Person/Firm served and Address	Means of service: e.g. mail/certified mail/fax/FedEx Fax number, if by fax	(time, if by fax)
ADMINISTRATIVE DIRECTOR		Cannot fax to Administrative Director

_____ _____

(Signature of Declarant) (date)

INSTRUCTIONS

Signing and Serving

The declarations and this form must be signed by Principals or Employees of the employer, insurance carrier, or administrator.
This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 71010, Oakland, CA 94612, and copies served by mail or physical delivery or fax on the employee, employee's attorney, and treating physician. The objection form and report may be served on the employee, employee's attorney, and treating physician by fax, but only if prior consent has been obtained from the recipient to be served by fax. This form may not be served on the Administrative Director by fax. This Objection must be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.

Declarations

The form contains two declarations to be signed under penalty of perjury. The first is a declaration specifying the date that the report containing the treating physician's recommendation was first received by the employer, insurance carrier, or administrator. The second declaration specifies the date and manner of serving of the objection.

The form includes two versions of the declaration specifying the date of receipt of the report. Only one version needs to be completed. Version A shall be completed by an employee having personal knowledge of the facts of when the report was received, such as the person who opened the mail. Version B shall be completed by an employee who knows from the date stamp when the report was received, if all mail to the firm is date-stamped on the date it is received, the signer is readily knowledgeable about the policy, the policy is consistently followed, and the report bears a legible date stamp.

The declaration regarding service of the objection must be signed by the person having knowledge of how the report was served.