

For DWC only: MPN Approval Number

Date Application Received: / /

Cover Page for Medical Provider Network Application

1. Name of MPN Applicant _____

2. Address

3. Tax Identification Number

_____ - _____

4. Type of MPN Applicant

Self-Insured Employer

Group of Self-Insured Employers

Self-Insured Security Fund

Joint Powers Authority

State

Insurer

5. Name of Medical Provider Network(s), if applicable:

6. If the medical provider network is one of the following deemed entities, check the appropriate box:

Health Care Organization (HCO)

Health Care Service Plan

Group Disability Insurer

Taft-Hartley Health and Welfare Trust Fund

7. Name of entity, administrator or other third-party who prepared MPN Application on behalf of MPN applicant (if applicable): _____

8. Signature of authorized individual: "I, the undersigned officer or employee of the MPN Applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and ability, the information included in this application is true and correct."

Name of Authorized Individual

Title

Phone/Email

Signature of Authorized Individual

Date Signed

9. Authorized Liaison to DWC:

Name

Title

Organization

Phone/Email

Address

Fax number

Submit an original Cover Page for Medical Provider Network Application with original signature, an original Application with the information required by Title 8, California Code of Regulations, section 9767.3 and a copy of the Cover Page and Application to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94612.

[DWC Mandatory Form – section 9767.4 – May 2007]