Sedgwick Claims Management Services, Inc.
P O Box 14450
Lexington, KY 40512-4450

Phone: (562)981-1700
Fax: (562)981-1760

05/11/2023

Ivan Androsov
1300 Lazzabee St 2
West Hollywood, CA 90069

RE: Employee: Ivan Androsov
Employer: Bloomingdale's Inc.
Claim Number: 4A2302G35KC-0001
Date of Injury: CT to 01/02/2023

NOTICE OF DENIAL OF CLAIM FOR WORKERS' COMPENSATION BENEFITS

Sedgwick is handling your workers' compensation claim on behalf of Bloomingdale's Inc. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

☒ After careful consideration of all available information, we are denying liability for your claim of injury. Workers' Compensation benefits are being denied because there is no factual or medical evidence that work caused stress/psych. Furthermore there is no evidence that the threshold for compensable stress/psych claim has been met .
☐ A copy of the report is attached to this notice.

☐ After careful consideration of all available information, we are accepting liability only for your claim of injury to . Liability is being denied for because .
☐ A copy of the report is attached to this notice.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claim administrator, Labor Code section 5402 (c) provides that within one working day after you file the claim form, the employer shall authorized the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such medical treatment until the claims administrative accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000).

Unless you have done so already, you should immediately send me all medical treatment bills for

consideration of payment for medical services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected.

☒ If you disagree with the decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

☐ We the comprehensive medical evaluation of and . If you choose to dispute this decision you may file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB).

☐ Since you have already received a comprehensive medical evaluation, if you disagree with the decision to deny your claim, please contact me Susana Juarez (818)265-4142 to arrange to return to the same medical evaluator for a new evaluation.

☒ If you are represented, you may contact your attorney with any questions.

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

The State of California requires that you be given the following information:
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call me Susana Juarez (818)265-4142. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not me Susana Juarez (818)265-4142.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

Keep this notice. It contains important information about your workers' compensation benefits.

Sedgwick cannot agree at this time to provide notices electronically via email.

Sedgwick manages claims on behalf of Bloomingdale's Inc..

We value your privacy. For more on what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection, please read our privacy notice www.sedgwick.com.

Sincerely,
Susana Juarez
Claims Examiner

Enclosures

(☐) Medical Reports(s) (if applicable)
(X) QME Panel request form (QME Form 105 and attachment) (to unrepresented employees)

cc: File
Natalia Foley, Esq

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

MAI Allergy & Immunology

MPA Pain Medicine

MDE Dermatology

MAI Dermatology - Allergy & Immunology

MEM Emergency Medicine

MTT Emergency Medicine - Toxicology

MFP Family Practice

MPM General Preventive Medicine

MTT General Preventive Medicine - Toxicology

MMM Internal Medicine

MAI Internal Medicine- Allergy & Immunology

MMV Internal Medicine - Cardiovascular Disease

MME Internal Medicine - Endocrinology Diabetes & Metabolism

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

MHH Orthopedic Surgery - Hand

MTO Otolaryngology

MHA Pathology

MPR Physical Medicine & Rehabilitation

MPA Physical Medicine & Rehabilitation - Pain Medicine

MPS Plastic Surgery (other than Hand)

MHH Plastic Surgery- Hand

MPD Psychiatry (other than Pain Medicine)

MPA Psychiatry - Pain Medicine

MSY Surgery (other than Spine or Hand)

MHH Surgery - Hand

MSG Surgery- General Vascular

MTS Thoracic Surgery

MUU Urology

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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