Change of Network Treating Doctor Request

Injured Worker

Injured worker name		
Address		
Insurance carrier & employer		
Claim number		
Date of injury		
Current treating doctor		

Please explain your reason for requesting a change of treating doctor:

_____

_____

_____ _____

Injured worker (**Required Signature)** Date

It is your responsibility to have your proposed treating doctor complete the following information and sign below.

Proposed Doctor

Doctor name		
Address		
Phone/fax numbers		

Do you accept responsibility to coordinate all of the injured worker's health care needs? _____

Please attach any additional documentation and/or medical records that will substantiate this request.

_____ _____

Physician (**Required Signature)** Date

Once completed, this form should be mailed or faxed to the claims adjuster.

Adjuster response

Decision	☐ Approved ☐ Denied* ☐ Other (see rationale below)	
Decision rationale		
Network name	CompKey +	
Adjuster name		
Phone/fax numbers		

Adjuster: Please forward a copy of the decision to the network

*Appeals process: Appeals may be filed with the network: CompKey Plus, 10535 Boyer Blvd Ste. 100, Austin TX 78758. Fax: (800) 580-3123, Phone (800) 580-1314, Email: compkey@careworks.com. Access the network complaint/appeal form online at https://www.careworks.com.