River View Provider Group - Change of Physician Form

Employee's Name		Current Treating Doctor's Name and Title	
Mailing Address	County of Residence	Mailing Address	
City State Zip Code	Phone Number	City State Zip Code	Doctor's Phone Number
Date of Birth	Date of Injury	Employer's Name	Employer's Phone Number
Have you returned to work? Yes ☐ No ☐		Employer's Mailing Address	

REQUEST TO CHANGE TO: _____

I agree to serve as treating doctor and to assume all of the responsibilities of a treating doctor under River View Provider Group requirements and other applicable governing laws and rules

_____	_____
Requesting Treating Doctor's Signature & Date	Professional License Number
Requested Treating Doctor's Name	Telephone Number
Mailing Address	Title

REASON TO CHANGE:

If your request is to change treating doctors, please provide the reason(s) for your need to request a new treating doctor:

Request Approved: _____
Authorized Signature and Date

Request Denied. Reason: _____
_____

Exception (check one):
Current Treating Doctor referred you to this doctor ☐

Current Treating Doctor retired, died, or is no longer contracted with River View Provider Group ☐

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