

Send Completed Form To: Zurich Insurance PO Box 968044 Schaumburg, IL 60196-8044 FAX: 973-394-5262

CHANGE OF PHYSICIAN

PLEASE ENSURE TREATING PHYSICIAN IS A PROVIDER IN THE COMPNET MANAGED HEALTH CARE NETWORK

1. Claimant's Name: 2. Claim Number: 3. Social Security Number – Last four digits: 4. Date of Injury: I am presently being treated by: I am requesting to change to: PLEASE ENSURE TREATING PHYSICIAN IS A PROVIDER IN THE COMPNET MANAGED HEALTH CARE NETWORK Address of requested physician (Street, City, State, Zip): My reason for changing physicians:		
3. Social Security Number – Last four digits: 4. Date of Injury: I am presently being treated by: I am requesting to change to: PLEASE ENSURE TREATING PHYSICIAN IS A PROVIDER IN THE COMPNET MANAGED HEALTH CARE NETWORK Address of requested physician (Street, City, State, Zip):	. Claimant's Name:	
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Address of requested physician (Street, City, State, Zip):	am presently being treated by:	
My reason for changing physicians:	address of requested physician (Street, City, State, 2	Zip):
	My reason for changing physicians:	
I have checked with the requested physician to see if he/she will take me as a patient: Yes No	have checked with the requested physician to see if	f he/she will take me as a patient: Yes No
Claimant's Signature Date	Claimant's Signature	Date

SAWC-RCP-OO 10/13