STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

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:
I have checked with the requested physician to see if he/she will take me as a patient: ☐ Yes   ☐ No

Claimant's Signature	Date