

## Request for Change / Opt-Out

Return completed form to: American Mining Claims Service P. O. Box 660988 Birmingham, AL 35266-0988

☐ Change of Physician	Opt-Out of Provider Network
1. Claimant's Name:	
2. Claim Number:	
3. Social Security Number:	
4. Date of Injury:	
	Seek treatment with an out-of-network physician
I am presently being treated by:	
I am requesting to change to:	
Address of requested physician (Street, City, State, Zip):	
My reason for changing physicians or seeking treatment out of network:	
I have checked with the requested physician to see if he / she will take me as a patient:	☐ Yes ☐ No
Claimant's Signature	Date