STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

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