COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

# REQUEST FOR CHANGE OF PHYSICIAN

Claimant _____ Date of Injury _____

Claimant's Telephone # _____ Insurance Carrier _____

Employer _____ Insurance claim # _____

WC# (if applicable) _____

I am requesting a change of authorized treating physician/facility from _____ (name of current physician/medical facility) to _____ (name of requested physician/medical facility). If proposing more than one new physician/facility, a list may be attached on a separate sheet.

**CERTIFICATE OF SERVICE:** Copies of this document were placed in the U.S. mail, hand-delivered, faxed or emailed to the following parties this _____ (Day) day of _____ (Month), _____ (Year).

List the name(s) and mailing address(es), fax number(s) or email address(es) of all person(s) copied:

Respondents' Representative(s): _____

_____

_____

By: _____
Signature

**RESPONSE TO REQUEST (Check one box and return to claimant)**
**The request to change physicians is:**

☐ **GRANTED:** If approval is granted, write the name of the new physician/facility on the line below:

_____

☐ **DENIED**

**CERTIFICATE OF SERVICE:** Copies of this document were placed in the U.S. mail, hand-delivered, faxed or emailed to the claimant this _____ (Day) day of _____ (Month), _____ (Year).

List the name(s) and mailing address(es), fax number(s) or email address(es) of all person(s) copied:

Claimant or Claimant's Attorney: _____

_____

_____

By: _____
Signature