

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
REQUEST/OBJECTION FOR CHANGE OF PHYSICIAN/ADDITIONAL TREATMENT

When you receive this completed form, you must file a response with the Board within 15 days of the date on the certificate of service (O.C.G.A. §9-11-6(e)). All responses must be filed on Form WC-200b.

A. IDENTIFYING INFORMATION

Employee Name _____
Address _____

Soc. Security No. _____
Date of Injury _____
County of Injury _____
MCO Yes No

B. PHYSICIANS/TREATMENT

1. The currently authorized treating physician is Dr.:

Name _____
Address _____

2. Authorization is requested for treatment by Dr.:

Name _____
Address _____

3. The additional treatment requested is:

C. ACTION REQUESTED

This action is being requested by _____ Employee _____ Employer _____ Insurer

_____ 1. A request is being made for change of primary treating physician to Dr _____

_____ 2. A request is being made for additional medical treatment to be provided by Dr _____ The current authorized primary treating physician shall remain authorized.

_____ 3. An objection is being filed by _____ Employee _____ Employer _____ Insurer

This request/objection is based upon the following (attach supporting documentation):

- | | |
|--|--|
| _____ Proximity of physician's office to employee's residence. | _____ Excessive/redundant performance of medical procedures. |
| _____ Accessibility of physician to employee. | _____ Noncompliance by physician with Board Rules and procedures. |
| _____ Necessity for specialized care. | _____ Number of physicians who have treated the employee. |
| _____ Language barrier. | _____ Prior requests for change of physician or treatment. |
| _____ Referral by authorized physician. | _____ Employee released to normal duty work by current authorized physician. |
| _____ Panel of physicians. | _____ Duration of treatment without appreciable improvement. |
| _____ Other: See Board Rule 200(b)(2). | _____ Current physician indicates nothing more to offer. |
| | _____ WC/MCO internal dispute resolution process (procedure attached) |

D. CERTIFICATION

I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.

PRINT NAME HERE

SIGNATURE

DATE

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).