

Form 102

**APPLICATION TO CHANGE DOCTORS**

\_\_\_\_\_  
 Name of Injured Person Carrier File No. \_\_\_\_\_  
 \_\_\_\_\_  
 Home Address (street) Social Security No. \_\_\_\_\_

\_\_\_\_\_  
 City/State/Zip Home Phone Number

On \_\_\_\_\_, 20\_\_\_\_\_, I sustained an injury/occupational disease arising out of and in the course of my employment at \_\_\_\_\_

\_\_\_\_\_  
 Employer Name

\_\_\_\_\_  
 Employer Address

\_\_\_\_\_  
 City/ State/ Zip

\_\_\_\_\_  
 Phone Number

Briefly describe how accident occurred, parts of body injured, and results \_\_\_\_\_

I have been treated by the following doctors (Give full names and addresses in the order in which they were seen): \_\_\_\_\_

I asked my present doctor for a referral. Yes \_\_\_\_\_ No \_\_\_\_\_ Referral was approved. Yes \_\_\_\_\_ No \_\_\_\_\_  
 I would like permission to change from Dr. \_\_\_\_\_

(Give full name, title [M.D., D.C., etc.], address and zip)

To Dr. \_\_\_\_\_

(Give full name, title [M.D., D.C., etc.], address and zip)

My reasons for wanting to change are:

**MAIL THIS REQUEST TO:**

Insurance Carrier/Adjustor \_\_\_\_\_

Street or Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Adjuster Email \_\_\_\_\_

**ACTION ON REQUEST**

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Denied by: \_\_\_\_\_ Date: \_\_\_\_\_

Reasons for denial: \_\_\_\_\_

\*\*\*Copies of this form approved or denied, must be sent promptly to the applicant and to the doctor the applicant has requested to be the treating physician. Per R612-300-2, after an injured worker has exercised his or her one-time right to change health care providers, the worker must use this form to request payor approval of any subsequent change of provider.



160 East 300 South 3<sup>rd</sup> Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610  
 Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 [www.laborcommission.utah.gov](http://www.laborcommission.utah.gov)