

Optional Form

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer). If I have a work-related injury or illness, I choose to be treated by:

(name of doctor) (M.D., D.O., or medical group)

(street address, city, state, ZIP)

(telephone number)

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee's Signature: _____

Date: _____

Physician: I agree to this Predesignation:

Signature: _____

Date: _____

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3). Title 8, California Code of Regulations, Section 9783. (Optional DWC Form 9783, July 1, 2014)

Note to Employee: Unless an employee agrees, neither the employer nor the claims administrator shall contact your personal physician to confirm a predesignation [CCR 9780.1(f)]. If your physician did not sign above, other documentation that they agreed to be predesignated prior to the injury will be required. If you agree that after receiving this form your employer or claims administrator may contact your physician to confirm the predesignation sign below:

Employee Signature: _____

Employee I.D. # _____

Date: _____

Note to Physician: California workers' compensation medical services are subject to utilization review for medical necessity; reporting requirements; and the California Official Medical Fee Schedule. The following optional information may assist communication and facilitate the authorization, reporting, recordkeeping and payment processes:

Office Manager/Billing Contact: _____

Phone: _____

Mailing Address (if different from street address): _____

Fax: _____

Email: _____

Physician License #: _____

Physician Tax I.D. #: _____