

**DEPARTMENT OF LABOR AND INDUSTRIES
 CLAIMS SECTION
 PO BOX 44291
 OLYMPIA WA 98504-4291**

Note: Please fold in thirds using mark along the left edge so the address will show in a window envelope.

If you have changed attending health care providers, you must notify and obtain authorization from your claims manager. We are sending you this card to request a change of attending providers. Please fill out and return this card as soon as possible to ensure your medical services are not interrupted.

To: Department of Labor and Industries	Claim No.
	Date I changed health care providers

Please transfer my medical case

Name of provider	
From:	
Name of provider	Provider ID# / NPI#
To:	
Address of new provider	City State ZIP

Reason for transfer _____

Today's date	Claimant's name
Address	
City State ZIP	

Claimant's signature _____