

CHOICE OF DOCTOR STATEMENT

This form is requested by our Third Party Administrator (TPA), Contract Claims Services, Inc., to expedite the claims process.

The injured worker fills out this form once they decide upon their treating doctor.

After the injured party completes all sections of the form, please mail to the following address:

Contract Claims Services, Inc.
P.O.Box 541328
Dallas, Tx 75354-1328

CHOICE OF DOCTOR STATEMENT

. _____ Date Completed	. _____ Date of Injury/Illness
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. _____ Employee Name

I choose as my physician (Emergency Room Physician excluded)
Doctor's Name . _____ .
Office Name (if applicable) . _____ .
Address. _____ .
City, State, Zip. _____ .
Telephone. _____ .
Specialty (if known). _____ .

. _____ Signature of Associate/Claimant
. _____ Address
. _____ City/State/Zip
. _____ Telephone Number

Return this form to: Contract Claims Services, Inc., P.O.Box 541328, Dallas, Tx 75354-1328