NOTICE OF PHYSICIAN CHOICE

Employee's Name: ____

Employer's Name: ____

Injury Date: ____

I am claiming to have sustained an injury involving my ___________________.
(indicate part of body)

I am ______ am not _______ claiming that my medical condition is work related.
(check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

- ❑ I accept as my choice of physician my employer's suggested physician to provide treatment and that choice is Dr. ____________________________

- ❑ I elect to choose my own physician to provide treatment and that choice is Dr. ____

____
Employee's Signature

____
Date

Witnessed By: ________________________

____

Copy to Employee, Employer and CorVel (within 24 hours)
CorVel Fax #: 866-434-4720