

**WC-200b REQUEST / OBJECTION FOR CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT**  
**GEORGIA STATE BOARD OF WORKERS' COMPENSATION**

**REQUEST / OBJECTION FOR CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT**

REQUEST  OBJECTION

Instructions: When you receive this complete form, you must file a response with the Board within 15 days of the date on the certificate of service (O.C.G.A. §9-11-6 (e)). All responses must be filed on Form WC-200b

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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**A. IDENTIFYING INFORMATION**

<b>EMPLOYEE</b>	County of Injury		Name of counsel (if represented)		
	Address		City	State	Zip Code
<b>INSURER / SELF-INSURER</b>	Name		Name of counsel (if represented)		
	Name		Claim Office Address		
<b>CLAIMS OFFICE</b>		E-mail Address		SBWC ID# (five digit no.)	City
				State	Zip Code

**B. PHYSICIANS / TREATMENT**

1. The currently authorized treating physician is Dr.:		Address		
Name _____		City	State	Zip Code
2. Authorization is requested for:		Address		
<input type="checkbox"/> a Change of Physician to _____ <input type="checkbox"/> additional treatment _____ Name _____		City	State	Zip Code

**C. ACTION REQUESTED**

This action is being requested by:  Employee  Employer  Insurer

1. A request is being made for change of primary treating physician to Dr. \_\_\_\_\_

2. A request is being made for additional medical treatment to be provided by Dr. \_\_\_\_\_  
 The current authorized primary treating physician shall remain authorized.

3. An objection is being filed by:  Employee  Employer  Insurer

This request / objection is based upon the following (attach supporting documentation):

<input type="checkbox"/> Proximity of physician's office to employee's residence	<input type="checkbox"/> Excessive/redundant performance of medical procedures
<input type="checkbox"/> Accessibility of physician to employee	<input type="checkbox"/> Noncompliance by physician with Board Rules and procedures
<input type="checkbox"/> Necessity for specialized care	<input type="checkbox"/> Number of physicians who have treated the employee
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Prior requests for change of physician or treatment
<input type="checkbox"/> Referral by authorized physician	<input type="checkbox"/> Employee released to normal duty work by current authorized physician
<input type="checkbox"/> Panel of physicians	<input type="checkbox"/> Duration of treatment without appreciable improvement
<input type="checkbox"/> Other: See Board Rule 200 (b) (2)	<input type="checkbox"/> Current physician indicates nothing more to offer
	<input type="checkbox"/> WC/MCO internal dispute resolution process (procedure attached)

**D. ENTRY OF APPEARANCE**

I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or Form WC 102B filed in compliance of Board Rule 102. (fee contract or Form WC 102B has been filed previously or is attached).

**E. CERTIFICATE OF SERVICE**

I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation 270 Peachtree St, NW, Atlanta, GA 30303-1299 and to all parties and counsel in this claim.

Print Name Here	Phone Number	Address		
Signature	Date	City	State	Zip Code
E-mail		GA Bar number		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.ga.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).