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.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Name of counsel (if represented)		
Mailing Address		City	State	Zip Code

INSURER / SELF-INSURER	Name		Name of counsel (if represented)		
CLAIMS OFFICE	Name		Mailing Address		
SBWC ID# (five digit no.)	E-mail Address	Phone Number	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		
☐ a Change of Physician to _____			
☐ additional treatment _____	City	State	Zip Code
Name _____			

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):

- ☐ Proximity of physician's office to employee's residence
- ☐ Accessibility of physician to employee
- ☐ Necessity for specialized care
- ☐ Language barrier
- ☐ Referral by authorized physician
- ☐ Panel of physicians
- ☐ Other: See Board Rule 200(b)(2)
- ☐ Excessive/redundant performance of medical procedures
- ☐ Noncompliance by physician with Board Rules and procedures
- ☐ Number of physicians who have treated the employee
- ☐ Prior requests for change of physician or treatment
- ☐ Employee released to normal duty work by current authorized physician
- ☐ Duration of treatment without appreciable improvement
- ☐ Current physician indicates nothing more to offer
- ☐ 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.sbwc.georgia.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).