Mail to:

Insurance Carrier Name: _____ State File No. _____

Insurance Carrier Address: _____ Ins. Co. File No. _____

Insurance Carrier City/State/Zip: _____ Date of Injury _____

Insurance Carrier Adjuster: _____

NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one suggested or assigned to them by their employer, **regardless** of the reasons for the change, at **any time** during the course of treatment after the first appointment.

Employee Name: _____

Address: _____

City/State/Zip: _____ Home Telephone: _____

E-mail Address: _____ Work Telephone: _____

I am changing my medical care for my work-related injury from the first treating health care provider selected by my employer to the provider of my choice.

FIRST TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

NEW TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

I am changing because:

- ☐ I would rather treat with my family health care provider.
- ☐ I believe another health care provider is better able to treat my symptoms.
- ☐ I have previously treated with another health care provider.
- ☐ Other (please describe below):

_____

This notice should be presented to the employer/insurance carrier prior to changing health care providers to fulfill the requirements of Vermont law, [21 V.S.A. § 640(b)]. Notice is not required for subsequent changes of provider after the first change of provider form is submitted.

_____

Print Employee Name

_____ _____

Employee Signature Date