EMPLOYEE PHYSICIAN PREDESIGNATION FORM

TO BE COMPLETED PRIOR TO DATE OF INJURY

To: _____ (name of employer). I acknowledge receipt of my insurer's notice of its approved Medical Provider Network for any work-related injuries I may have in the future.

At this time I wish to use my own predesignated physician and affirm he/she has treated me in the past and has retained my medical records for my past medical care:

Physician Name: _____ M.D. or D.O.
(Specify)

_____
Physician Address (Street; City, State and Zip code)

Physician Phone No: (_____) _____

Physician: I agree to this predesignation for: _____
Employee Name

_____
Employee Address (Street; City, State and Zip code)

_____ _____
Physician's Signature Date

I understand that my physician must agree to act as my Primary Treating Physician under Markel Insurance Company/FirstComp MPN for my work-related injury. In the event the above named physician is not appropriate for my work related injury or does not agree to act in this capacity, I will be required to seek care with one of my employer's MPN physicians or facilities.

I agree to the above conditions.

_____ _____
(Employee's Signature) (Date)

_____
(Employee's Full Name)

_____
(Name of Employer)

***Note to predesignated physician**: By agreeing to treat this patient for work related injuries, you also agree to abide by the Division of Workers' Compensation (DWC) rules pertaining to Primary Treating Physician's reporting duties pursuant to Title 8, California Code of Regs, § 9785, et seq.*

Markel Insurance Company/FirstComp
FirstComp; P.O. Box 3009; Omaha, NE 68102-1680