



**CCMSI**  
**HISD WC 504 Provider Panel**  
**Employee Request to Change Treating Doctor**



**INSTRUCTIONS**

Please complete the form below and submit to CCMSI by:

**\*All Fields Are Required to Warrant a Complete Request**

- fax – (713) 218-8579; or
- email – [Houstonisd@CCMSI.com](mailto:Houstonisd@CCMSI.com); or
- mail – CCMSI; Attn: HISD Panel Support; PO Box 3309; Bellaire, TX 77402

A decision will be mailed to you within 30 days of receipt of this request.

**I. Employee Information**

|                |  |       |  |                  |  |                 |  |
|----------------|--|-------|--|------------------|--|-----------------|--|
| First:         |  | Last: |  | MI:              |  | Date of Injury: |  |
| Date Of Birth: |  | SSN:  |  | Claim Number:    |  |                 |  |
| Address:       |  |       |  | City:            |  |                 |  |
|                |  |       |  | State:           |  |                 |  |
|                |  |       |  | Zip:             |  |                 |  |
|                |  |       |  | County / Parish: |  |                 |  |
| Phone:         |  | Fax:  |  | Email:           |  |                 |  |

**II. Current Treating Doctor Information**

|                                 |  |      |  |                  |  |  |  |
|---------------------------------|--|------|--|------------------|--|--|--|
| Provider Name:                  |  |      |  |                  |  |  |  |
| Provider Group (if applicable): |  |      |  |                  |  |  |  |
| Address:                        |  |      |  | City:            |  |  |  |
|                                 |  |      |  | State:           |  |  |  |
|                                 |  |      |  | Zip:             |  |  |  |
|                                 |  |      |  | County / Parish: |  |  |  |
| Phone:                          |  | Fax: |  | Email:           |  |  |  |

**III. Reason for Requesting Change of Treating Doctor**

Explain Why You Are Requesting to Change Your Treating Doctor (Attach additional sheets if necessary.):

|  |
|--|
|  |
|--|

**IV. Requested Treating Doctor Information:**

|                                 |  |      |  |                  |  |  |  |
|---------------------------------|--|------|--|------------------|--|--|--|
| Provider Name:                  |  |      |  |                  |  |  |  |
| Provider Group (if applicable): |  |      |  |                  |  |  |  |
| Address:                        |  |      |  | City:            |  |  |  |
|                                 |  |      |  | State:           |  |  |  |
|                                 |  |      |  | Zip:             |  |  |  |
|                                 |  |      |  | County / Parish: |  |  |  |
| Phone:                          |  | Fax: |  | Email:           |  |  |  |

**V. Requested Treating Doctor's Signature:**

|                                 |  |  |  |  |  |       |  |
|---------------------------------|--|--|--|--|--|-------|--|
| Provider's Name (Please Print): |  |  |  |  |  |       |  |
| Provider's Signature:           |  |  |  |  |  | Date: |  |

**I. Employee's Signature:**

By Signing this form I confirm that I wish to change my treating doctor, and I authorize my current treating doctor to furnish records pertaining to my work injury claim to the requested treating doctor.

|                       |  |       |  |
|-----------------------|--|-------|--|
| Employee's Signature: |  | Date: |  |
|-----------------------|--|-------|--|

|                  |                          |                             |  |      |  |
|------------------|--------------------------|-----------------------------|--|------|--|
| Request Approved | <input type="checkbox"/> | CCMSI Rep:                  |  | Date |  |
| Request Denied   | <input type="checkbox"/> | See Attached Appeal Process |  |      |  |

## Frequently Asked Questions

### Employee Request to Change Treating Doctor

#### Under what circumstances am I required to submit an Employee Request to Change Treating Doctor?

Should you become dissatisfied with your first choice of treating doctor, you have the right to select an initial change of treating doctor from within the HISD WC 504 Provider Panel. You may contact your Claims Adjuster or Nurse Case Manager for assistance in selecting a new doctor. For any subsequent changes, you must submit an Employee Request to Change Treating Doctor form for approval before changing treating doctors for a valid reason including, but not limited to:

- you believe treatment provided by your current treating doctor is medically inappropriate;
- there is a conflict between you and your current treating doctor to the extent that the doctor- patient relationship is jeopardized or impaired; or
- your current treating doctor chooses to discontinue treatment. Provide documentation from your current treating doctor, if available.

You may **not** request a change of treating doctor to obtain a change in work status.

#### Where do I submit my Employee Request to Change Treating Doctor form?

You can submit the form and any supporting documentation to CCMSI by:

fax - (713) 218-8579; or

email – [Houstonisd@CCMSI.com](mailto:Houstonisd@CCMSI.com); or

mail – CCMSI; Attn: HISD Panel Support; PO Box 3309; Bellaire, TX 77402

**IMPORTANT NOTE:** **Completion of all fields are required to warrant a complete request.** If you fail to obtain Panel approval prior to receiving treatment from the new treating doctor, you may be responsible for the cost of treatment and the insurance carrier may be relieved of responsibility for payment. To obtain Panel approval, you must submit an Employee Request to Change Treating Doctor form.

#### What does CCMSI do?

Within 30 days of receiving the signed Employee Request to Change Treating Doctor form, CCMSI will review and process the request.

If the request is approved, CCMSI will issue an approval letter and send a copy to the injured employee, injured employee's representative (if any), prior treating doctor and newly approved treating doctor.

If the request is denied, CCMSI will issue a denial letter and send a copy to the injured employee, injured employee's representative (if any), and requested treating doctor.

#### Appeals

In the event that your Change of Physician Request is denied, you have the right to appeal that decision by submitting a written request to CCMSI via fax, e-mail or regular mail to the same address used for the Change of Physician form (noted above). The appeal request, along with any additional information you would like to be considered, must be received within ten (10) days of the original denial notice receive date. Appeals will be decided by a review panel ("the Appeal Panel") consisting of the Medical Director, the CCMSI Account Manager, the Utilization Review Consultant (Novare Texas, LLC) Account Manager, the Bill Review consultant (Novare Texas, LLC) Account Manager (if applicable) and Legal Counsel approved by the Provider Panel. All appeals will be decided within twenty one (21) days of receipt of a timely appeal request. Written notice will be provided to you of the Appeal Panel's decision along with the reason(s) for same.