TASB Risk Management Fund
P.O. Box 2010 • Austin, Texas 78768-2010 • 800.482.7276
12007 Research Blvd. • Austin, Texas 78759-2439 • tasbrmf.org
Administered by the Texas Association of School Boards

Alliance Treating Doctor Change Request

Notice to injured worker: You have the right to choose an initial treating doctor from the Alliance list of medical providers. Within the first 60 days of treatment, you are allowed one change of treating doctor to another on the Alliance panel. Please complete this form and send it to your adjuster when you choose a second doctor. If you wish to change doctors again, or if you have treated with the initial treating doctor for a period greater than 60 days, please complete this form and **send it to your adjuster for approval**. You must obtain approval from the TASB Risk Management Fund (Fund) **before** you treat with a new treating doctor and your request may require documentation (i.e., medical report or affidavit, etc.). For assistance, call the Fund at 800.482.7276.

1. Employee's Name (Last, First, MI)		8. Current Treating Doctor's Name (Last, First, MI) and Title	
2. Mailing Address (Street or PO Box)		Address (Street), City, State Zip Code	
City, State, Zip Code		9. Employer's Name	Phone Number
3. Social Security Number	4. Date of Injury	Mailing Address (Street or PO Box)	
5. Type of Injury	6. Phone Number	City, State, Zip Code	Phone Number
7. Have you returned to work? ☐ Yes, full duty ☐ Yes, light duty ☐ No, not at all		10. Insurance Carrier: **TASB Risk Management Fund**	

Reason for Change (Signature Required)

11. Please give reason(s) for your need to request a new treating doctor and **attach documentation to support your request**:

Request Change to

12a. I agree to serve as treating doctor and to assume all the responsibilities of a treating doctor under the Political Subdivision Workers' Compensation Alliance (Alliance) contract and Provider Manual. In specific cases where there is no treating doctor within 30 miles, an exception may be made by the adjuster to approve a non-Alliance treating physician.

Signature: _____ License #: _____ Date: _____

12b. Requested Treating Doctor's Name (Printed)	12c. Phone Number
Mailing Address (Street or PO Box)	
City, State Zip Code	12d. Title

13. **Workers' Compensation Related Medical Records Release**
I hereby authorize_____to furnish records pertaining to my workers' compensation claim to the
(*current treating doctor*)
requested treating doctor shown in block 12a of this form. All associated costs related to furnishing the records will be paid by the insurance carrier. This authorization is in compliance with Section 408.025, Texas Workers' Compensation Act, Texas Labor Code.

14. Employee's Signature (Required)	Date	Date Stamp Box

For the Fund Only

☐ **Request Approved** The TASB Risk Management Fund will pay for all reasonable and necessary treatment provided by the requested treating doctor in accordance with the Alliance Contract, Act and Division Rules. The Fund requests the current treating doctor to provide a complete copy of all the employee's medical records to the approved requested treating doctor.

☐ **Request Denied** Reason: _____

☐ **Exception:** _____

Adjuster Signature	Date	
	Phone Number	

Copy ☐ Employee ☐ Attorney ☐ The Fund ☐ Current Doctor ☐ Requested Doctor

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Information for Request to Change Treating Doctors

To the injured employee: The Political Subdivision Workers' Compensation Alliance, as authorized by Texas Labor Code §504.053, provides that you may request authority to select a third treating doctor from the Alliance list of medical providers if you are dissatisfied with the initial and second choice of doctors. Certain exceptions apply and justification with documentation may be required for reasons that are not exceptions. **Unless a medical necessity exists for an immediate change, you must request a change of treating doctors on this form. If medical necessity for an immediate change exists, then you may notify your adjuster by telephone**. Failure to obtain approval from the Fund can result in your being responsible for cost of treatment from the new treating doctor and the Fund being relieved of responsibility for payment.

A change of treating doctor may not be made to obtain a new impairment rating or medical report.
In order to be approved these sections must be filled out.

Required Information	
1. Employee's Name	Your complete name.
2. Mailing Address	Your complete address, including ZIP code.
3. Social Security Number	Your Social Security Number.
4. Date of Injury	Date your injury occurred, or date occupational disease was diagnosed.
5. Type of Injury	Body part(s) injured.
6. Phone Number	Your complete telephone number.
7. Return to Work	Complete the requested information regarding your Return To Work status.
8. Current Treating Doctor	Name, Title, and address including ZIP code and Telephone number
9. Employer's Name, Phone Number, and Address	Information on Employer at time of injury.
10. Insurance Carrier's Name	Name of employer's insurance carrier when you were injured.
11. Reason(s) for Need to Change	Explanation with documentation of why you are requesting to change to a new treating doctor.
12a. Acceptance	The requested doctor's signature and professional license number. **Contact the requested doctor's office prior to filing this form to verify the doctor will assume the responsibilities of a treating doctor and acquire signature.**
12b. Requested Treating Doctor's Name and Mailing Address (printed)	Printed name of doctor whom you are requesting to be the primary doctor responsible for health care related to your injury or occupational disease. Requested treating doctor's address, including ZIP code.
12c. Phone Number	Requested treating doctor's office telephone number.
12d. Title	Title, if known, of requested doctor. Example: MD, Doctor of Medicine.
13. Workers' Compensation-Related Medical Records Release Authorization	Your signature will authorize your new treating doctor, if approved by the Fund, to obtain your medical records from your current treating doctor to prevent unnecessary duplication of tests and examinations.
14. Employee's Signature and Date	Your complete signature and the current date

Fund response to request:
Within 10 days from receiving your request, you will receive a response to your request. If approved, the requested doctor becomes your treating doctor, and the Fund will pay for reasonable and necessary treatment provided by the approved doctor unless another request is approved later. If you fail to wait until you receive approval from the Fund before going to the requested doctor, the Fund may not be liable for the payment of those medical bills.

Alliance Treating Doctor Change Request

In order to request a change of treating doctors after the initial and an alternate, the employee must complete this form, mail, e-mail or fax the form to the Fund. If medical necessity exists for an immediate change, the request may be made by telephoning the adjuster. Within 10 days of receiving the request, theadjuster will act on the request. If the reason for requesting the change meets the criteria established bystatute, rule and the Fund's procedure, the requested change will be approved by the Fund.

The employee should obtain the requested treating doctor's agreement to serve as treating doctor prior to submitting this form the Fund. The employee must sign the form which authorizes the current treating doctor to release workers' compensation medical information to the requested treating doctor to avoid unnecessary duplication of tests and examinations and to provide the requested treating doctor with past medical records.

The form further states that when the order is approved, the Fund will be responsible for all reasonable and necessary treatment provided by the new treating doctor in accordance with the statute and rules unless the decision is set aside by a subsequent approved request.