Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 804-4378 fax

Complete if known:
DWC Claim #
Carrier Claim #

Employee Request to Change Treating Doctor

For use ONLY by Employees NOT in Workers' Compensation Health Care Networks or Certain Political Subdivision Health Care Plans
Type (or print in black ink) each item on this form

I. EMPLOYEE/EMPLOYEE'S ATTORNEY INFORMATION

1. Employee's Name (First, Middle, Last)	**2. Employee's Social Security Number**	
3. Employee's Mailing Address (Street or PO Box, City, State, Zip Code)		
4. Employee's Telephone Number ( )	**5. Alternate Telephone Number** (if available) ( )	**6. Date of Injury** (mm/dd/yyyy)
7. Attorney/Representative's Name (if applicable)	**8. Attorney/Representative's Address** (Street or PO Box, City, State, Zip Code)	

II. EMPLOYER INFORMATION (at the time of the injury)

9. Employer's Name	**10. Employer's Address** (Street or PO Box, City, State, Zip Code)

III. INSURANCE CARRIER INFORMATION

11. Insurance Carrier's Name	**12. Insurance Carrier's Address** (Street or PO Box, City, State, Zip Code)	
13. Adjuster's Name	**14. Adjuster's Telephone Number** ( ) ext.	**15. Adjuster's Fax Number** ( )

IV. TREATING DOCTOR INFORMATION

Current Treating Doctor

16. Current Treating Doctor's Name (First, Middle, Last) **and Title** (MD, DO, DC, etc.)	**17. Current Treating Doctor's Telephone Number** ( ) ext.
18. Current Treating Doctor's Mailing Address (Street or P.O. Box, City, State, Zip Code)	
19. Current Treating Doctor's License Number (if known)	**20. Current Treating Doctor's Fax Number** ( )

Reason for Requesting a Change of Treating Doctor

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

Requested Treating Doctor

22. Requested Treating Doctor's Name (First, Middle, Last) **and Title** (MD, DO, DC, etc.)	**23. Requested Treating Doctor's Telephone Number** ( ) ext.
24. Requested Treating Doctor's License Number	**25. Requested Treating Doctor's Fax Number** ( )
26. Requested Treating Doctor's Mailing Address (Street or P.O. Box, City, State, Zip Code)	
27. Requested Treating Doctor's Signature (required)	**28. Date** (mm/dd/yyyy)

V. EMPLOYEE'S AUTHORIZATION TO CHANGE TREATING DOCTORS AND RELEASE MEDICAL RECORDS

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 workers' compensation claim to the requested treating doctor.	For TDI-DWC Use Only
28. Employee's Signature (required)	
29. Date	

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Frequently Asked Questions
Employee Request to Change Treating Doctor (DWC Form-053)

For use ONLY by Employees NOT in Workers' Compensation Health Care Networks or Certain Political Subdivision Health Care Plans

Who may use this form to change treating doctors?

Only an injured employee (a) who is covered by the Texas workers' compensation system; (b) who has a claim with a date of injury or exposure on or after January 1, 1991; (c) who is **not** part of a certified workers' compensation health care network (network); and (d) whose claim does **not** involve medical benefits provided through a political subdivision (political subdivision health plan) pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool may use this form to request a change of treating doctor.

NOTE: *If you are in a network described in (c) above or a health plan described in (d) above, contact the network or health plan and follow their procedures for changing your treating doctor. If you do not know if you are in a network or this type of health plan, contact your workers' compensation insurance adjuster.*

Under what circumstances am I required to file the DWC Form-053?

You must file the DWC Form-053 to **request *Texas Department of Insurance, Division of Workers' Compensation* (TDI-DWC) approval before receiving services** from a new treating doctor if you are dissatisfied with the initial choice of treating doctor for a valid reason including, but not limited to:

- you believe treatment provided by your current treating doctor is medically inappropriate;
- you believe you are not receiving appropriate medical care to reach maximum medical improvement;
- you are concerned about the professional reputation of your current treating doctor;
- 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 not to coordinate your health care because of communication issues between the doctor and the insurance carrier regarding the processing of your medical bills. Provide documentation from your current treating doctor, if available.

You may **not** request a change of treating doctor to obtain a new impairment rating or medical report.

IMPORTANT NOTE: *If you fail to obtain TDI-DWC 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. In order to obtain TDI-DWC approval, you must file the DWC Form-053 unless an immediate change of treating doctor is medically necessary. In that case, you may contact the TDI-DWC field office handling your claim by telephone to obtain verbal approval.*

You must also file the DWC Form-053 to **immediately notify the TDI-DWC** if you change treating doctors because:

- you moved or changed residence; or
- your current treating doctor is unavailable or unable to provide medical care or has retired or died. Provide documentation from the doctor's office, if available.

Why is the new treating doctor's signature required?

You must confirm that the requested doctor will treat you by contacting the requested doctor's office, describing your injury and asking if the doctor is taking new workers' compensation patients. To verify that the doctor has agreed to treat you, you **must** have the doctor sign the DWC Form-053 in Box 27. The treating doctor must be a doctor as defined in the Texas Labor Code §401.011. A non-physician practitioner, e.g. a nurse practitioner or a physician's assistant, cannot be a treating doctor.

Where do I file the DWC Form-053?

You can submit the form and any supporting documentation to the TDI-DWC by:

- fax to (512) 804-4378; or
- mail to the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, MS-94, Austin, Texas 78744-1645.

What does the TDI-DWC do?

Within 10 days of receiving the signed DWC Form-053, the TDI-DWC will review and process the request.

- If the request is approved, the TDI-DWC will issue an approval order and send a copy to the injured employee, injured employee's representative (if any), insurance carrier, prior treating doctor and newly approved treating doctor.
- If the request is denied, the TDI-DWC will issue a denial order and send a copy to the injured employee, injured employee's representative (if any), insurance carrier and requested treating doctor.

NOTE: *If you do not agree with the TDI-DWC's decision, you must dispute the decision within 10 days of receiving the order. Contact the TDI-DWC field office handling the claim at 1-800-252-7031 for more information about the dispute process. The insurance carrier also has the right to dispute the decision.*