

### **Facts about Personal Physician Predesignation**

On 1-1-04, the California Labor Code section 4600(d) relative to the pre-designation of a personal medical doctor (M.D.) or a doctor of osteopathy (D.O.) for the treatment of an industrially related illness or injury was modified.

In order for a pre-designated physician to be authorized, the following conditions must be met:

- 1.) The employer offers group health coverage;
- 2.) The doctor has treated the employee in the past and has established medical records on the employee;
- 3.) *Prior to the injury*, the doctor has agreed to treat the employee for work injuries or illnesses;
- 4.) The employee has provided the employer the doctor's name and address in writing.
- 5.) If the employee has predesignated a personal chiropractor (D.C.) or acupuncturist (L.A.C.), in writing prior to the injury or illness, the claims administrator will arrange treatment with another doctor, then the employee may switch to the chiropractor or acupuncturist upon request during the first 30 days after the employer knows of the injury of illness.

Therefore, if you have employees that have existing personal physician predesignations on file with you, it is recommended that you review the predesignation requirements listed above with those employees.

Enclosed a blank, generic, personal physician predesignation form to be completed by those employees wishing to predesignate their physician. This must be signed by the predesignated physician and returned to the employer prior to an injury or illness being reported.

To: (name of employer) \_\_\_\_\_

If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
(Name of doctor)

Circle One (M.D., D.O., D.C., L.A.C.)

\_\_\_\_\_  
(street address)

\_\_\_\_\_  
(city, state, zip)

\_\_\_\_\_  
(telephone number)

I understand that this doctor must have treated me in the past and must maintain my medical records.

Employee name: (please print) \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Employee I.D. Number: \_\_\_\_\_

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**Physician: Complete this section.** I agree to treat the above named individual should they have a work injury or illness. I understand that medical services in the California workers' compensation system are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical fee Schedule promulgated by the Division of Workers' Compensation.

Physician name: (please print) \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Manager/Billing Contact Name(s): \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

Physician Tax I.D. Number: \_\_\_\_\_