



PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- On the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- Your employer offers group health coverage;
- The doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- Prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

Please send this notice directly to Intercare at the address below, provide a copy to your departmental personnel office, and keep a copy for your records.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (Name of your employer)

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

Name of doctor (M.D., D.O. or medical group): _____

Street address, city, state & ZIP: _____

Telephone number: _____ Fax number: _____

Employee name (please print first, middle, last): _____

Employee E-Mail: _____

DSW number: _____

Employee address: _____

Employee signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____

(Physician or designated employee of the physician or medical group)

*The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).
DWC FORM 9783 (7/2014)*

EMPLOYEE: Return original form to –

ATTN: MPN Department

InterMed CCS

P.O. Box 21947

Eagan, MN 55121

Or Email: MPNMedicalAssistant@intermedccs.com

Medical Access Assistant phone number: (877) 746-3157