WORKERS' COMPENSATION

Panel Physicians Form

The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work related injury. *If you do not use one of these physicians for your work related injury, you may be responsible for the cost of medical care*.

Please select a physician from this Panel, complete and sign this form and return it to your supervisor. The supervisor should immediately return this form to **M C INNOVATIONS (MCI) at P.O Box 1140, Richmond, VA 23218-1140. Phone 804/649-2288. Fax 804/371-2556 or via e-mail to covimaging@yorkrsg.com**

Please choose from the following list by writing the physician's name and signing the form. Return the form to your supervisor for filing with the claim application.

	1)	2)	3)
NAME	Physicians Treatment Center	OrthoVirginia	HealthWorks Occupational Ctr
ADDRESS	2832 Candlers Mountain Rd	2405 Atherholt Road	1905 Atherholt Road
	Lynchburg, VA 24502	Lynchburg, VA 24501	Lynchburg, VA 24501
PHONE	434-239-3949	434-485-8500	434-200-6933

(Please check the above PPO PHYSICIAN box if appropriate)

If the Rockport PPO Physician block is checked say the following when making your appointment with the doctor: "I am a Commonwealth of Virginia employee and you are listed as a participant in WELLCOMP'S ROCKPORT- VHN PPO NETWORK, and I have been directed to seek your services." If the provider has questions regarding their participation, they may contact Rockport Provider Services at 800.734.4460 or via email at ProviderServices@rhgnet.com.

Employee

By signing this form, I release all medical information to M C Innovations. All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected

Dr. ______________________________ to provide me with medical care for my work related injury.

Signed: ______________________________ Date: ______________

Printed: ______________________________ Date of Injury: ___________
NAME

Social Security Number: ______________________________

Revised 5/23/16