Send To: **DWC Local Office Handling Claim, if known,** or
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

CLAIM # _____

Carrier's Claim # _____

NOTICE: A request to change treating doctor may only be initiated by an injured employee. No other person shall be permitted to initiate this process or solicit this request.

EMPLOYEE'S REQUEST TO CHANGE TREATING DOCTORS

To the injured employee: *You must obtain approval from the Texas Department of Insurance Division of Workers' Compensation BEFORE you change to a new treating doctor* ***and your request may require documentation (****i.e., medical report or affidavit, etc.). If you need to change doctors, read the information on the back of this form and send the form to the local office handling your claim. For assistance, call the local office handling your claim or* ***1-800-252-7031****.*

1. Employee's Name (Last, First, M.I.)		8. Current Treating Doctor's Name (Last, First, M.I.) and Title	
2. Mailing Address (Street or P.O. Box)		Mailing Address (Street or P. O. Box)	
City State ZIP Code		City State ZIP Code	Telephone Number ( )
3. Social Security Number	4. Date of Injury	9. Employer's Name	Telephone Number ( )
5. Type of Injury	6. Telephone Number ( )	Mailing Address (Street or P. O. Box) City State ZIP Code	
7. Have you returned to work? ☐ Full Duty ☐ Light Duty ☐ No, not at all		10. Insurance Carrier's Name	

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 of the responsibilities of a treating doctor under the Texas Worker's Compensation Act, Texas Labor Code and any applicable rules related to the compensable injury

Requested Treating Doctor's Signature | Professional License Number | Date

12b. Requested Treating Doctor's Name (printed)	12c. Telephone Number ( )
	12d. Title
Mailing Address (Street or P.O. Box) City State ZIP Code	

13. **WORKERS' COMPENSATION RELATED MEDICAL RECORDS RELEASE AUTHORIZATION**

I hereby authorize _____ to furnish records pertaining to my workers' compensation claim to the requested
(current treating doctor)
treating doctor shown in Block 12a of this form. All associated costs related to furnishing the records will be governed by Workers' Compensation Rule 133.106 and Rule 133.2(b) and shall 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

DIVISION ORDER — FOR DIVISION USE ONLY

☐ **Request Approved. Order for Payment:** The Texas Department of Insurance, Division of Workers' Compensation by orders the insurance carrier to pay for all reasonable and necessary treatment provided by the requested treating doctor in accordance with the Act and rules unless set aside by a subsequent order. The Division hereby orders 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.** _____

Authorized DWC Employee's Signature	Date
Title	Phone Number ( )

Copy ☐ Employee ☐ Attorney ☐ Insurance Company ☐ Current Doctor ☐ Requested Doctor

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.

IMPORTANT INFORMATION ON REVERSE SIDE OF FORM

INFORMATION FOR REQUEST TO CHANGE TREATING DOCTORS (DWC FORM-53)

NOTICE: A request to change treating doctor may only be initiated by an injured employee. No other person shall be permitted to initiate this process or solicit this request.

TO THE INJURED EMPLOYEE: Texas Labor Code, Texas Workers' Compensation Act, Section 408.022 provides that an employee may request authority to select an alternate doctor if the employee is dissatisfied with the initial choice of doctor. Certain exceptions apply and justification with documentation may be required for reasons that are not exceptions. For explanation of exceptions, see our website at www.tdi.state.tx.us or contact the local office. **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 the local office handling your claim by telephone**. Failure to obtain Division approval can result in your being responsible for cost of treatment from the new treating doctor and the insurance carrier being relieved of responsibility for payment. Please follow the instructions below.

A CHANGE OF TREATING DOCTOR MAY NOT BE MADE TO OBTAIN A NEW IMPAIRMENT RATING OR MEDICAL REPORT.

DWC FORM-53 BLOCK INFORMATION		DWC REQUIRED INFORMATION
In order to be approved these sections must be filled out.		
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.	Telephone 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, Telephone 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.	Telephone Number	Requested treating doctor's office telephone number.
12d.	Title	Title, if known, of requested doctor. Example: MD, Doctor of Medicine, or DC, Doctor of Chiropractic.

13. **Workers' Compensation-Related Medical Records Release Authorization**. Your signature will authorize your new treating doctor, if approved by the Division, 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.

DIVISION ORDER:

Within 10 days from receiving your request, the local office will issue a response to your request. If approved, an order will be issued and the requested doctor becomes your treating doctor, and the insurance carrier will pay for reasonable and necessary treatment provided by the approved doctor unless another order is issued at a later date. If you fail to wait until you receive approval from the local office before going to the requested doctor, the insurance carrier may not be liable for the payment of those medical bills. The insurance carrier may not be responsible for payment of medical bills if you fail to comply with the rule to change treating doctors.

If you or the insurance carrier do not agree with the Division decision, contact the local office handling the claim **within 10 days of receipt** to request a benefit review conference.

DWC FORM - 53
(Employee's Request to Change Treating Doctors)

In order to request a change of treating doctors, in most situations the employee must complete DWC FORM-53, Employee's Request to Change Treating Doctors, and mail or deliver the form to the local office handling the claim. If medical necessity exists for an immediate change, the request may be made by telephoning the office handling the claim. Within 10 days of receiving the request, the local office will take action on the request. If the reason for requesting the change meets the criteria established by statute, rule and the Division's procedure, the requested change will be approved by the Division. A benefit review conference may be requested within 10 days after receiving the Division order if the employee or the carrier disagrees with the Division approval or denial of the request to change treating doctors.

The employee should obtain the requested treating doctor's agreement to serve as treating doctor prior to submitting DWC FORM-53 to the local office for consideration. 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 insurance carrier is 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 order.

[Texas Workers' Compensation Act, Texas Labor Code, Section 408.022, Selection of Doctor; Section 408.023, List of Approved Doctors; Section 408.024, Noncompliance with Selection Requirements; Rule 126.8, Division approved Doctor List; Rule 126.9, Choice of Treating Doctor and Liability for Payment; Rule 133.3, Responsibilities of Treating Doctor]