Out-of-Network Treating Doctor Request

Injured Worker

Injured worker name		
Address		
Insurance carrier & employer		
Claim number		
Date of injury		
Current treating doctor name		
Out-of-Network Doctor Information		
Doctor name		
Doctor address		
Doctor phone & fax		

Please explain your reason for requesting an Out-of-Network Doctor as your treating doctor:

_____

_____

_____

_____ _____

Injured worker (**Required Signature**) Date

FAX or mail the completed form to your claims adjuster.

You will be notified in writing of the outcome of the review within seven (7) calendar days from the receipt of your request. If you have any questions or need assistance in completing this form, please contact your adjuster.

Adjuster response

Decision	☐ Approved ☐ Denied* ☐ Other (see rationale below)	
Decision rationale		
Network name	Careworks HCN	
Adjuster name		
Phone/fax numbers		

Adjuster: Please forward a copy of the decision to the network

*Appeals process: Appeals may be filed with the network: Careworks HCN, 10535 Boyer Blvd Ste. 100, Austin TX 78758. Fax: (800) 580-3123, Phone (800) 580-1314, Email: careworkshcn@careworks.com. Access the network complaint/appeal form online at https://www.careworks.com.