Mark Gordon
Governor

State of Wyoming
Department of Workforce Services

DIVISION OF WORKERS' COMPENSATION
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Cheyenne, Wyoming 82009
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Robin Sessions Cooley
Director
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NOTICE OF CHANGE OF HEALTH CARE PROVIDER

Name:		Claim Number:
Address:		Date of Injury:
City:	State:	Zip:
SSN:		Phone: ( )

Current Health Care Provider:		Phone: ( )
Address:		
City:	State:	Zip:

Have you talked with your current treating health care provider about a referral to the requested health care provider? ☐ **Yes** ☐ **No**

Requested Health Care Provider:		Phone: ( )
Address:		
City:	State:	Zip:

Is this for a second opinion only**?** ☐ **Yes** ☐ **No**

I am changing health care provider(s) for the following reason(s):

Signature of Injured Worker **Date**

NOTE: ***Travel will only be reimbursed to the closest available health care provider. Wyoming Statute 27-14-401(d)***

We invite you to take our customer service survey by visiting http://bit.ly/wyworkcomp or by scanning this code with your smart phone or other mobile device

We Bridge Human and Economic Development for Wyoming's Future.

CLAIMS
Phone 1-307-777-7441
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https://piers.wyo.gov