encova INSURANCE

REQUEST FOR CHANGE OF PHYSICIAN

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

1. Claimant name
2. Claim number
3. Social Security number
4. Date of injury

I am requesting to ☐ Change physicians to another network provider ☐ Seek treatment with an out-of-network physician
I am presently being treated by
I am requesting to change to
Address of requested physician (street, city, state, ZIP)
My reason for changing physicians or seeking treatment out of network
I have checked with the requested physician to see if he/she will take me as a patient. ☐ Yes ☐ No

Claimant signature	Date