Mark Gordon
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

Robin Sessions Cooley
Director

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
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https://piers.wyo.gov