Date: [Date]

To: [Claims Adjuster Name/Insurance Carrier]
Address: [Insurance Company Address]
City, State, Zip: [City, State, Zip]

RE: Notice of Transfer of Care

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Employer: [Employer Name]

Dear [Claims Adjuster Name],

This letter is to formally notify you that [Patient Name] has requested to transfer their medical care for the above-referenced workers' compensation claim to my office, [New Clinic/Doctor Name], effective [Effective Date].

The patient was previously under the care of [Previous Physician/Facility Name]. We have requested the transfer of all relevant medical records and imaging to ensure continuity of care.

Enclosed/Attached please find the following documentation:

- The patient's formal request/signed authorization for change of physician.
- Our initial evaluation report and proposed treatment plan.
- Form [Insert State Specific Form Number, e.g., PR-2 or CMS-1500].

Please update your records to list [New Physician Name] as the Primary Treating Physician (PTP). All future correspondence, authorization requests, and medical reports should be directed to our office at the address listed below.

If you have any questions or require further information regarding this transfer, please contact our workers' compensation coordinator at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Credentials]
[Practice Name]
[Tax ID Number]
[NPI Number]
[Office Address]
[Phone/Fax Number]