UC Irvine Health

Human Resources
200 S. Manchester Ave., Suite 800
Orange, CA 92868

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EMPLOYEE'S PRE-DESIGNATION OF PERSONAL PHYSICIAN

TO: UCIMC- Human Resources - Workers' Compensation Unit
200 S. Manchester
Orange, CA 92868
P: (714) 456-6597
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Email: mcwcdm@uci.edu

Physician Pre-designation

You can be treated immediately by your personal medical doctor (M.D.) or a doctor of osteopathy (D.O.) if:

- Your employer offers group health coverage;
- The doctor has treated you in the past and has your medical records;
- Prior to the injury the doctor agreed to treat you for work injuries or illnesses and you have already given
- Your employer the doctor's name and address in writing.

The above describes "pre-designating a personal physician." If you give your employer the name and address of a personal chiropractor (D.C.) or acupuncturist (L.AC.) in writing, prior to the injury or illness, your claims administrator will arrange treatment with another doctor, then you may switch to the chiropractor or acupuncturist upon request during the first 30 days after your employer knows of your injury or illness. You can notify your employer by completing the following form and returning it to your employer.

Employee: Complete this section.

To: UC IRVINE HEALTH

If I have a work-related injury or illness, I choose to be treated by (name of doctor):

_____

_____

Address:

_____

City, State, ZIP: Telephone:

I understand that this doctor must have treated me in the past and must maintain my medical records.

Employee Name (please print): _____

Employee Signature: _____ Date: _____

Employee I.D. Number _____

Physician: Complete this section.

I agree to treat the above named individual should they have a work injury or illness. I understand that medical services in the California workers' compensation system are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical Fee Schedule promulgated by the State Division of Workers' Compensation.
Physician Name (please print):

_____
Physician Signature:

_____
Office Manager/Billing Contact Name(s):

_____
Street Address:

_____
Mailing Address (if different):

Telephone: _____ Fax: _____

Email: _____ Physician Tax I.D. Number: _____