



Request for Change / Opt-Out

Return completed form to:
BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

Change of Physician

Opt-Out of Provider Network

	1. Claimant's Name:
	2. Claim Number:
	3. Social Security Number:
	4. Date of Injury:

	I am requesting to: <input type="checkbox"/> Change physicians to another network provider <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No

Claimant's Signature	Date
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