

**Form 113**

Designation of Physician

Revised 8-15-96

COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF WORKERS CLAIMS  
1270 LOUISVILLE ROAD  
FRANKFORT, KENTUCKY 40601  
Claim No. \_\_\_\_\_

**NOTICE OF DESIGNATED PHYSICIAN**

**EMPLOYEE:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

(\_\_\_\_)\_\_\_\_\_  
Telephone Number

**EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**NATURE OF INJURY OR OCCUPATIONAL DISEASE:** \_\_\_\_\_

**DATE OF INJURY OR LAST EXPOSURE:** \_\_\_\_\_

**FIRST DESIGNATED PHYSICIAN:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

(\_\_\_\_)\_\_\_\_\_  
Telephone Number

Accepted by: \_\_\_\_\_

**MEDICAL INFORMATION RELEASE:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

**MEDICAL PAYMENT OBLIGOR:**

**KESA  
200 Executive Park  
Louisville, KY 40207-4202**

**(502) 894-8484 or  
(800) 367-5372  
(502) 894-0066 Fax**

Notice: The Workers Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as ? designated physician.? The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the worker's compensation medical payment obligor for medical services.