The Designated Provider List Notification Letter should be created on your company's letterhead and include the information below. This letter should be hand-delivered or mailed to your injured worker.

SAMPLE

Designated Provider List Notification Letter for an Injured Worker

1

To: [Insert employee's name]

From:

Date: [You must provide this letter at the time you are informed of the employee's injury]

Subject: Designated Provider List Notification Letter

I am sorry to learn that you have been injured. To make sure you receive the care you need, we are filing a claim with our workers' compensation insurance carrier, Pinnacol Assurance. Pinnacol will contact you with your claim number and additional information very soon. In the meantime, you should see one of the medical providers we have selected to treat our injured employees. These medical providers specialize in on-the-job injuries, and I want you to have the best possible care.

2

Name:	**Name:**
Address:	**Address:**
City, State & Zip:	**City, State & Zip:**
Phone:	**Phone:**
[insert information of Medical Provider #1]	[insert information of Medical Provider #2]
Name:	**Name:**
Address:	**Address:**
City, State & Zip:	**City, State & Zip:**
Phone:	**Phone:**
[insert information of Medical Provider #3]	[insert information of Medical Provider #4]

Please contact one of these medical providers to be seen as soon as possible. After your first appointment, please follow up with me so we can review your medical status and work capabilities.

The respondent's representative is our workers' compensation insurance company, Pinnacol Assurance. Please see the contact information below.

Pinnacol Assurance
7501 E. Lowry Blvd
Denver, CO 80230-7006
303.361.4000 or 800.873.7242

If you have questions, please contact me. My goal is to ensure that you get the care you need to recover quickly and return to work as soon as possible.

Organization Name and Phone
Address
City, State & Zip

] [please insert organization's information]

3

Employer's Representative for Workers' Compensation:

Name:
Phone:

] [The name and phone number should be of the person you have identified at your organization to handle your workers' comp claims]

❑ Hand delivered on: _____[date]_____

❑ Mailed to injured worker on: _____[date]_____

4

_____
Employer's Signature

_____ _____
Employee's Signature [preferred but not required] **Date**

If you have questions regarding this letter or your medical providers, please contact your Pinnacol Assurance underwriter at 303.361.4000.