

To: Department of Labor and Industries Claim No: \_\_\_\_\_

**Please transfer my case** Date (changed health care providers): \_\_\_\_\_

**From:** (Name of provider)

**To:** (Name of new provider)

Provider ID # / NPI#:

Address of new provider:

City:

State:

Zip:

Reason for transfer:

Claimant's name:

Today's date:

Address:

City:

State:

Zip:

Claimant's signature:

F245-037-000 Transfer of Care Card 04-2014

Index: TCARE

**Fax to: 360-902-4567**

**Or**

**Mail to:**

**Department of Labor and Industries**

**Claims Section**

**PO Box 44291**

**Olympia WA 98504-4291**