



# Transfer of Care Form

Claims  
PO Box 44291  
Olympia WA 98504-4291

Complete form and return to Department of Labor and Industries  
Fax – 360-902-4567

Or

Mail to:  
Department of Labor and Industries  
Claims Section  
PO Box 44292  
Olympia WA 98504-4291

Claim Number: \_\_\_\_\_

Please Transfer my case \_\_\_\_\_  
Date (changed health care providers)

Name of Current Provider	Provider ID #/NPI #
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Name of New Provider	Provider ID #/NPI #
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Address of New Provider			
Street	City	State	Zip Code

Reason for Transfer:
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Claimant's Name	Today's Date		
Address	City	State	Zip

Claimant's Signature
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