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 09-2012 Index: TCARE

Mail to:
Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291