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**