

# WORKERS' COMPENSATION

## Panel Physicians Form



The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work related injury. *If you do not use one of these physicians for your work related injury, you may be responsible for the cost of medical care.*

Please select a physician from this Panel, complete and sign this form and return it to Libby MacDonald  
Watermens Hall Room 231 (804) 684-7201.

The form will then be returned to:

**MANAGED CARE INNOVATIONS (MCI) at P.O Box 1140, Richmond, VA 23218-1140.  
Phone 804/649-2288. Fax 804/371-2556.**

1) John Lynch, P.A.

NAME

Velocity Urgent Care

ADDRESS

5659 Parkway Drive, Ste. 100  
Gloucester, VA 23061

Office: 804-381-4361

Fax: 804-220-9405

PHONE

M-F 8am-8pm  
Sat/Sun 9am-3pm

2) Phi Lam, M.D.

NAME

Patient First

ADDRESS

611 Denbigh Blvd.  
Newport News, VA 23608

Office: 757-283-8300

Fax: 757-283-8301

PHONE

M-Sun 8am – 10 pm

3) Chan S. Park. M.D.

NAME

MD Express

ADDRESS

6567 Geo. Wash. Mem. Hwy  
Gloucester, VA 23061

Office: 804-824-9962

Fax: 804-824-9963

PHONE

M-Sun 9am – 9pm

## Employee

By signing this form, I release all medical information to Managed Care Innovations. All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected

Dr. \_\_\_\_\_ to provide me with medical care for my work related injury.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
NAME

Printed: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
NAME

Agency Representative: \_\_\_\_\_  
Printed name Signature Date