

CLIENT TRANSFER REQUEST FORM

CLIENT INFORMATION

Client Name: _____ Date: _____

OSOS ID: _____ Phone #: _____

TRANSFER INFORMATION

Current Service Provider: _____

Name of Requested Service Provider: _____

Specific Reason for Transfer: _____

Client Signature: _____ Date: _____

Current Service Provider Signature/Title: _____ Date: _____

TRANSFER REVIEW

WC Representative Signature: _____ Date Received: _____

Transfer Approved: Yes No By: _____ Date: _____

***(WC will notify requested Service Provider of availability of file within 3 working days)**

RECEIPT OF FILE

Requested Service Provider Representative (print name): _____

***(Upon Receipt, the new service provider will have 2 working days to accept or decline the file)**

If declined, give reason: _____

Signature: _____

Date Received: _____