# Designated medical provider

If you have designated a medical provider for the initial treatment of work-related injuries and have informed employees where they can seek treatment, please complete this form and return it to the State Insurance Fund.

Name and address of your designated provider:

________________________________________

________________________________________

________________________________________

________________________________________

Do you have a written contract with your designated provider?

Yes ☐ No ☐

Your business name:

________________________________________

Policy number: __________________________

Please return this form to the State Insurance Fund as an e-mail attachment. E-mail to: claims@isif.state.id.us. Or mail a hard copy to the State Insurance Fund, Attn. Designated Provider Form, PO Box 83720, Boise, ID 83720-0044.