Instructions
Workers Compensation Network Acknowledgement Form

Deadline for Submission:
This form should be completed and submitted within ***2 business days***.

Completed by:
The injured employee should complete this form. If the employee is incapacitated the spouse, child or legal guardian may sign the form. This form must be signed and dated.

Instructions:

1. The injured employee must clearly print his or her name on the printed name line.
2. The injured employee must clearly sign his or her name & date on the signature/date line.
3. The injured employee must clearly print his or her address, city, state & zip code on the address line.
4. The injured employee must print name of employer on the name of employer line.
5. **Give this form to your supervisor or their designated representative.**

Workers' Compensation Network
Acknowledgement Form

I have received the Notice of Network Requirements which informs me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®*.** Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed Acknowledgement Form:

Name of Employer: _______________________

Employee ID #: ___________________________ **Name of Network:** IMO Med-Select Network®

Hire Date: _______________________________ **Department**: ___________________________

Home Address: ____
Street Address – No P.O. Box or Work Address

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City **State** **Zip Code** **County**

____ ______________________
Employee Signature **Date**

____ ______________________
Printed Name **Employee Phone Number**

Revised 8.5.14