Workers' Compensation Acknowledgement Form

Please read this acknowledgement form, fill it out, sign it, and submit it to Environmental Health and Safety.

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.

Name of Carrier: The University of Texas System c/o CCMSI
Name of Network: IMO Med-Select Network®

Employee ID#: _____
Hire Date: _____
Department: _____

Home address (no PO Boxes, please): _____
City: _____
State: _____
ZIP Code: _____

Home phone number: _____

_____
Employee's name

_____ _____
Employee's signature Date