## The University of Texas at Arlington



## Workers' Compensation Network Acknowledgement Form



I have received information (Notice of Network Requirements & Employee Handbook Material) 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:

- I must choose a treating doctor from the list of physicians in the *IMO Med-Select Network*<sup>\*</sup>. (A list of physicians can be found at <u>www.injurymanagement.com</u>) 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.
- 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. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

Name of Carrier: The University of Texas System Name of Network: IMO Med-Select Network®

Home Address:					
	Street Address – No P.O. Box or Work Address				
-	City	State	Zip Code	County	
Printed Name		Date of	Injury	Employee Phone Number	
Employee Signa	ture	Date	Em	ail	

For more information please contact the office of Environmental Health & Safety at (817) 272-2185