



The University of Texas System (UT), Office of Risk Management is pleased to inform you that we have contracted with the IMO Med-Select Network (IMO) to provide medical treatment for UT System employees with work-related injuries or illnesses.

In accordance with the *Texas Labor Code*, all employees of the UT System institutions who are injured in the course and scope of their employment are entitled to reasonable and necessary medical care to treat their work-related injury or illness. The UT System is self-insured for workers' compensation insurance and the program is administered by the Office of Risk Management.

Beginning **April 1, 2013**, if you are injured on the job and you elect to seek care outside of M.D. Anderson Cancer Center's Employee Health & Well-being Clinic, you will be required to obtain medical care from an IMO network provider unless it is an emergency. If you have a medical emergency, you should go to the closest urgent care center or emergency room. IMO is a Texas Department of Insurance certified workers' compensation health care network. The IMO Med-Select Network includes over 3,000 credentialed providers including treating physicians and specialists. Approximately 85% of injured UT System employees are already being treated by providers in the IMO network.

MD Anderson employees may continue to seek care for work-related injuries/illnesses through the Employee Health Clinic. [MD Anderson Cancer Center's Employee Health Clinic](#) is located in the 1MC Building and is open Monday – Friday 7:30am to 4:30pm. The main number to the clinic is: 713-745-6900. Employee Health should be notified immediately of any employee accident/injury. An Employee Health Nurse Case Manager is available to assist you with questions/concerns related to any work-related injury/illness at MD Anderson Cancer Center.

Current claims handling procedures will remain in effect for injuries occurring before March 1, as well as for injured workers who live outside the network service area. To determine if you are in the network service area please follow the link below to the Notice of Network Requirements and see the list of counties covered by the network.

This network only applies for work-related injuries and has no impact on health insurance benefits offered by The University of Texas System.

Texas Department of Insurance requires that employees be notified that the UT System has a health care network. Network related information can be found @ <http://www.utsystem.edu/orm/wcihcnetwork/wcinetwork.htm>

The language in the acknowledgement form attached is required by the Texas Department of Insurance and the reference to an HMO may not apply to you.

IF FURTHER INFORMATION IS NEEDED PLEASE CONTACT *Employee Health and Well-being- 713-745-6900*

The University of Texas M.D. Anderson Cancer Center
For more care and information please contact Employee Health & Well-being - 713.745.6900



**Workers' Compensation Network
Acknowledgement Form**

I have received information (Employee Welcome Letter, Notice of Network Requirements and 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:

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 Carrier: The University of Texas System

Employee ID #: _____ Name of Network: IMO Med-Select Network

Hire Date: _____ Department: _____

Home Address: _____

Street Address – No P.O. Box or Work Address

City

State

Zip Code

County

Employee Signature

Date

Printed Name

Employee Phone Number

The University of Texas M.D. Anderson Cancer Center
Para obtener más información póngase en contacto con
Employee Health and Well-Being– 713.745.6900



Red de compensación al trabajador
Recibo de Información

He recibido la información (Carta de bienvenida al empleado, Notificación de requisitos para utilizar la Red y Documentación del manual de empleado) que me explica cómo obtener atención médica a través de la Red de compensación al trabajador.

Si me lastimo en el trabajo y vivo en el área de servicio descrita en esta información, entiendo que:

1. Debo elegir un médico tratante de la lista de médicos pertenecientes a la red de **IMO Med-Select Network**. O puedo pedir a mi médico de atención primaria en mi HMO que acepte ser mi médico tratante, para lo cual debo llenar el Formulario # OMI MSN-5, titulado Médico de atención primaria de HMO como médico tratante del seguro de compensación al trabajador.
2. Debo recurrir a mi médico tratante de la red para toda atención médica relacionada con mi lesión. Si necesito a un especialista, mi médico tratante hará el referido. Si necesito una atención de emergencia, puedo ir a cualquier lugar.
3. El UT System pagará al médico tratante y demás proveedores de atención médica de la red.
4. Es posible que me vea obligado a pagar la factura si recibo atención médica de alguien que no pertenezca a la red sin obtener autorización de la red.
5. Si recibo la Notificación de requisitos para utilizar la red y si niego a firmar el Recibo de Información, aún estoy obligado a utilizar la red.

Sírvase proporcionar la siguiente información antes de firmar y enviar este formulario de recibo de información:

Nombre de la compañía: The University of Texas System

de ID de Empleado: _____ Nombre de la red: IMO Med-Select Network

Fecha de empleo: _____ Departamento: _____

Domicilio: _____

Calle – No se admiten apartados de correo ni la dirección del trabajo

Ciudad

Estado

Código postal

Condado

Firma del empleado

Fecha

Nombre y apellidos en letra de molde

Número de teléfono del empleado