Please return form with the First Report of Injury to the WCI office via fax, (214) 645-35O4, or by email, to WorkersCompensation@UTSouthwestern.edu.

UT Southwestern Medical Center

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 an employee receives the Notice of Network Requirements and refuses to sign the Acknowledgement form, *they are 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 Person #: ______________________ **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**

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