



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 form to RMI by Fax# (713)500-8111, encrypted emails to (sondra.k.faul@uth.tmc.edu) or OCB 1.330. **HCPC Employees should give form to their supervisor or supervisor on duty.

Employee ID: _____

Name of Network: IMO Med-Select Network

Hire Date: _____

Department: _____

Home Address: _____

Street Address-No PO Box or Work Address

City	State	Zip Code	County
------	-------	----------	--------

Employee Signature

Date

Printed Name

Employee Phone Number

**For more information please contact the
Office of Safety, Health, Environment & Risk Management-713.500.8127 or 8111**