The University of Texas at Austin

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 acknowledgement form:

Name of Carrier: The University of Texas System c/o CCMSI

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

Hire Date: _____ **Department**: _____

Date of Injury: _____

Home Address: _____

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

_____

City **State** **Zip Code** **County**

_____ _____

Employee Signature **Date**

_____ _____

Printed Name **Employee Phone Number**

For immediate care and information please contact Health Point - Human Resource Services - 512.471.4647