



**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: [Environmental Health Safety & Risk Management, Attn: Diana Trelles, Smith House-736 Oscar Smith Ave, dt03@txstate.edu](mailto:dt03@txstate.edu)

Name of Employer: _____

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