



# The University of Texas Rio Grande Valley

## 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<sup>®</sup>**. 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<sup>®</sup>

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

For more information please contact the Department of Environmental Health & Safety - 956.665.3690