



UT Southwestern Medical Center Workers' Compensation Network Acknowledgement Form

I have received information (Notice of Network Requirements & 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®**. (A list of physicians can be found at www.injurymanagement.com) 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.

Name of Carrier: The University of Texas System

Name of Network: IMO Med-Select Network®

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

Home Address (Not P.O. Box or work address): _____

County (of Home Address): _____

Employee phone number: _____

Employee email: _____

Date of injury (if applicable or put N/A if new employee): _____

Printed Name: _____

Date: _____

Employee Signature: _____

Please return form with the First Report of Injury to the WCI office via fax, (214) 645 3504,
or by email to: WorkersCompensation@UTSouthwestern.edu