Deadline for Submission:
This form should be completed and submitted within 2 business days.

Completed by:
The injured employee should complete this form. If the employee is incapacitated the spouse, child or legal guardian may sign the form. This form must be signed and dated.

Instructions:
1. The injured employee must clearly print his or her name on the printed name line.
2. The injured employee must clearly sign his or her name & date on the signature/date line.
3. The injured employee must clearly print his or her address, city, state & zip code on the address line.
4. The injured employee must print name of employer on the name of employer line.
5. Give this form to your supervisor or their designated representative.
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 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