

# **Instructions**

## **Workers Compensation Network Acknowledgement Form**

### **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.**

## Workers Compensation Network Acknowledgement

I have received information that tells 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 doctors in the network.
2. I may ask my HMO primary care physician to agree to serve as my treating doctor.
3. I must go to my 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.
4. The insurance carrier will pay the treating doctor and other network providers.
5. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

I live at \_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(County)

Name of Employer \_\_\_\_\_

Name of Network \_\_\_\_\_