Employee Acknowledgment of Workers’ Compensation Network

By signing this form, I acknowledge and understand the following:

* I received the packet of information that tells me how to receive healthcare services through my employer’s workers’ compensation insurance.
* If I am hurt on the job and live in the service area described in the packet, I must choose a treating doctor from a list of doctors in the Prime Health Services network, or I may ask my primary care physician to act as my treating doctor. If I select my primary care physician, I will call toll-free 1-866-348-3887 to notify Prime Health Services of my choice.
* I must go to my treating doctor for all healthcare for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
* An insurance carrier will pay my treating doctor and other network providers.
* I might have to pay the bill if I get healthcare, other than emergency care, from someone other than a network doctor without the network’s approval.

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SignatureDate

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Printed Name

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Home Address

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 City State Zip Code

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 *Name of Employer*

Name of Network: **Prime Health Services Texas HCN**

Call Prime Health Services at 1-866-348-3887 if you need to locate a network treating doctor.

Please indicate whether this is the: **□** Initial Employee Notification (no injury involved); or

 □ Injury Notification (date of injury: **/**  **/**  )

 *Month Day Year*

**\*RETURN THIS FORM TO YOUR EMPLOYER. DO NOT SEND TO PRIME HEALTH SERVICES.\***