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 health care 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 1-888-512-5454 (toll-free) to notify EK Health Services of my choice.
- ✓ 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.
- ✓ An insurance carrier will pay my treating doctor and other network providers.
- ✓ I might have to pay the bill if I get health care, other than emergency care, from someone other than a network doctor without the network's approval.

_____ _____
Signature *Date*

_____
Printed Name

_____
Home Address

_____ _____ _____
City *State* *Zip Code*

_____
Name of Employer

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

Call EK Health Services at 1-888-512-5454 f 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 EK HEALTH SERVICES. **