The University of Texas at Arlington

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*.

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.

Name of Carrier: The University of Texas System **Name of Network:** IMO Med-Select Network®

Home Address:_____

Street Address – No P.O. Box or Work Address

_____

City **State** **Zip Code** **County**

_____ _____ _____

Printed Name **Date of Injury** **Employee Phone Number**

_____ _____ _____

Employee Signature **Date** **Email**

For more information please contact the office of Environmental Health & Safety at (817) 272-2185

UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F401
11/2023

University of Texas at Arlington

Employee's Report of Work-Related Injury or Occupational Disease

Personal Information:

Employee Name: _____ UT EID: _____ Email Address: _____

Home Phone: _____ Mailing Address: _____ City: _____Zip: _____

Work ext. or best number to reach you during working hours: _____

Date of Birth: _____ ☐ Male ☐ Female Race: ☐ Black ☐ White ☐ Asian ☐ NA

Marital Status: ☐ Married ☐ Unmarried ☐ Separated Spouse's Name: _____ ☐ NA # Dependent Children? _____ ☐ NA

Position/Title: _____ Department Where Employed: _____

Incident Information:

Date of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m. Date Supervisor was notified: _____

Direct Supervisor's Name: _____ Direct Supervisor Contact Number: _____

Name of management you reported the injury to, if different than direct supervisor: _____

Contact Number: _____

Worksite location of injury (Ex.: Administration Bldg., Sidewalk, Corridor by 2nd floor elevators, Lab, etc.)

Building/Room#_____ Description of Area_____

If off campus, location and physical address: _____

Describe below how the injury or exposure occurred. (Ex.: I left my office walking to the elevator, my shoe caught on carpeted hallway, and I tripped/fell striking right shoulder on floor OR I struck the top of my left hand with a screwdriver while trying to put together a desk for my office.)

Describe the resulting 'physical' injury (s) (Ex.: sprained left ankle, bruised left shoulder, laceration on top of head)

Did anyone witness the injury? Yes ☐ No ☐ List witness name (s) and contact information below.

1. _____ Contact # or email _____

2. _____ Contact # or email _____

3. _____ Contact # or email _____

Please select all body parts where you were injured and check the appropriate boxes.

	Left	Right	Both			Left	Right	Both
Abdome/Stomach ☐	☐	☐	☐		**Head** ☐	☐	☐	☐
Ankle ☐	☐	☐	☐		**Hip** ☐	☐	☐	☐
Arm ☐ **upper** ☐ **lower** ☐	☐	☐	☐		**Knee** ☐	☐	☐	☐
Back ☐ **upper** ☐ **lower** ☐	☐	☐	☐		**Leg** ☐ **upper** ☐ **lower** ☐	☐	☐	☐
Buttocks ☐	☐	☐	☐		**Multiple Body Parts** ☐	☐	☐	☐
Chest (includes ribs/sternum) ☐	☐	☐	☐		**Neck** ☐	☐	☐	☐
Ear ☐	☐	☐	☐		**Nose** ☐	☐	☐	☐
Elbow ☐	☐	☐	☐		**Sacrum/Coccyx Tailbone** ☐	☐	☐	☐
Eye ☐	☐	☐	☐		**Shoulder** ☐	☐	☐	☐
Face ☐	☐	☐	☐		**Throat** ☐	☐	☐	☐
Foot ☐	☐	☐	☐		**Teeth** ☐	☐	☐	☐
Hand ☐	☐	☐	☐		**Wrist** ☐	☐	☐	☐
Finger thumb ☐ **index** ☐ **middle** ☐ **ring** ☐ **little (pinky)** ☐					**Toe 1st** ☐ **2nd** ☐ **3rd** ☐ **little toe** ☐ **great toe** ☐			

Medical Information:

Please complete and return the Workers' Compensation Network Acknowledgement Form which informs you how to get healthcare under workers' compensation insurance. Please review the Notice of Network Requirements and obtain the WC Pharmacy First Fill /Text2Fill form.

I have been offered medical treatment but do not wish to receive any now. Initials_____
I understand this does not prevent me from seeking medical treatment later.

If seeking initial medical treatment, please provide the information below:

_____
Clinic or Hospital Name

_____
Physician

_____
Phone

_____
Address of clinic:

The above statement is true and accurate to the best of my knowledge. I confirm that the accident described above happened while I was performing duties that were assigned to me by UTA (University of Texas Arlington).

I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with the Environmental Health and Safety and/or other UTA/UT System depts. for improvements in workplace safety and preventing accidents and injury. It may also be shared with Office of Talent, Culture, and Inclusion for designation of Family Medical Leave, if applicable.

Injured Employee's Signature_____ Date _____

Scan and email completed form to workerscompensation@uta.edu.

UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F402
11/2023

Supervisor's Report of Employee Work-Related Injury or Occupational Disease

Personal Information:

Name of Injured Employee: _____ Employee Extension: _____ Does not have personal extension □

What is the best number to contact employee? _____

Does your injured employee speak English? Yes □ No □ If no, what language? _____

Job Information:

Employee's Position/Title: _____ Dept. Where Employed: _____

Length of service in current position:_____ Employee's normal work week (Ex.: Mon-Fri, 7am - 4pm, no lunch) _____

Please provide the current leave balances as of the date of injury. Sick: _____ *Vacation:* _____ *Compensatory:*_____

Incident Information:

Date of Injury: _____ Time of Injury: _____ a.m. □ p.m. □

When were you notified about this injury? Date: _____ Time: _____ a.m. □ p.m. □

Are you the employee's direct supervisor? Yes □ No □ If no, who is the direct supervisor? _____

Has your employee missed a full workday(s) because of this injury (excluding the day of injury)? Yes □ No □

Excluding the day of injury, what was the first scheduled workday missed? _____ N/A □

Return to work date (if known):_____

Worksite where injury happened (Ex: Administrative Bldg., Sidewalk, 2nd floor elevators, Lab):

Building/Room # _____

Description of Area _____

Based on your inquiry, what was your employee doing at the time of the injury. *(Ex.: "The employee stated he was walking into the building, slipped on the wet tile and fell to his knees causing a bruise to his left knee").*

When the injury happened, was your employee performing their regular duties or a specific task assigned to them? Yes □ No □

If no, please describe what they were doing at the time of the reported injury.

Was there physical evidence of injury to the claimed body parts? Yes □ No □ N/A □

If yes, please describe (Ex.: scratch on upper left arm, cut to top of head/scalp, bruised right knee)

Were there any witnesses to this injury? Yes □ No□ If yes, list name(s) and phone number(s). Attach an additional sheet, if necessary.

1. _____ Contact # or email _____

What do you think may prevent this type of accident from happening in the future?

Medical Information:

Did you provide the employee the required WC Network Acknowledgement form & Notice of Network Requirements packet on how to get healthcare under workers' compensation insurance? Yes □ No □

Initial Medical Treatment: Yes □ No □ First Aid Only Yes □ No □ Physician/Treatment Facility Yes □ No □ ER Visit Yes □ No □

Supervisor's Signature: (**Required):** _____Date: _____

Print Supervisor's Name: _____Ext._____Supervisor's Email Address: _____

This form was completed by ***(if other than the supervisor)***:

Print Name _____ Ext: _____Email Address: _____

Scan completed forms and email to workerscompensation@uta.edu

Please be aware that signing this report is not an admission by or evidence against UT Arlington. The information contained in this report only documents the supervisor's knowledge or version of how this incident occurred.

(You may be entitled to know what information The University of Texas at Arlington (UT Arlington) collects concerning you. You may review and have UT Arlington correct the information according to procedures set forth in UTS 139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.)

Revised: 11/23

WORKERS' COMPENSATION FOR UT ARLINGTON EMPLOYEES

Health care providers should send bills for work-related injuries to:

UT System c/o CCMSI
P.O. Box 2940
Clinton, IA 52733-2940
(888) 802-0692
uts@ccmsi.com

Do not use employee's personal health insurance.
It is an administrative violation to bill the injured employee directly for workers' compensation treatment.

UTS WCI Network - IMO
(214) 217-5939
www.injurymanagement.com

UT AT ARLINGTON

First Fill Prescription Instructions

RxBridge

Get Your Work-Related Injury Prescriptions Filled at **NO COST!**



Follow these 4 simple steps to receive your First Fill Prescription Card.

1. Text **UTA00** to **833-377-8345**
2. **Follow the Step-by-Step Instructions**
3. **Receive Your First Fill Card on Your Phone**
4. **Take your card and prescription to the pharmacy**

PARTICIPATING PHARMACIES

Including all major pharmacy chains & most independent pharmacies.
A full list of participating pharmacies can be found at www.RxBridge.com.

COMMON PARTICIPATING PHARMACIES

COSTCO	SAM'S CLUB
CVS PHARMACY	WALGREENS
MEDICINE SHOPPE	WALMART

Important Tips

- Tell the pharmacy your prescription(s) are for a work-related injury.
- Ask your doctor to note "Work-Related" on the prescription.
- Your First Fill Card covers a temporary supply while your claim is processed.
- Once your claim is accepted, you'll receive your permanent prescription card.

24/7

HAVING TROUBLE AT THE PHARMACY?
CALL 833-792-7434 IMMEDIATELY

Calling us while you are still at the pharmacy helps us resolve issues quickly so you can receive your medications at no cost.

Workers' Compensation Program

IMO Med-Select Network is the network in which you will use to gain access to medical care for your injury. For emergency care you may seek treatment at the nearest emergency facility.

The following is a partial list of clinics near campus.

Care Now
5405 S. Cooper
Arlington, 76017
817-465-4928

Care Now
8450 Eastchase
Fort Worth, 76120
817-459-2005

Care Now
2520 W. I-20
Grand Prairie, 75052
972-264-5858

Concentra
2160 E. Lamar Blvd.
Arlington, 76006
972-988-0441

Concentra
511 E. I-20
Arlington, 76018
817-261-5166

Concentra
2500 W. Freeway (I-30)
Ft. Worth, 76102
817-882-8700

Concentra-West
5900 I-20 W
Arlington, 76017
682-226-6001

Concentra
2045 N Hwy 360 Ste 100B
Grand Prairie, 75050
972-623-1111

Concentra Telemed

Fit Temple 365
1241 W. Green Oaks Blvd.
Arlington, 76013
817-704-3365

Baylor Scott & White Urgent Care
4401 Little Road Ste. 520
Arlington, 76016
682-318-3114