

Employee Acknowledgement of the Alliance Direct Contracting Program

I have received information that tells me how to get healthcare under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treatment doctor from the Alliance list of doctors designated as treating doctors.
2. 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 to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.
7. If I want to change doctors after my first choice, I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

Signature

Printed name

Date

I live at: _____
Street address

City/State/Zip code

Name of employer:

Conroe Independent School District

Name of Direct Contracting Program:

Political Subdivision Workers' Compensation Alliance
(*The Alliance*)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA website at www.pswca.org or call your adjuster at 800.482.7276.

To be completed by employer only

Please indicate whether this is the:

- initial employee notification
 injury notification (*date of injury: ____ / ____ / ____*)

Do not return this form to the TASB Risk Management Fund unless requested.

Reconocimiento del Empleado Para el Programa de Contratar Directamente con Medicos

He recibido la información que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escoger un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necesito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro de la Alliance.
4. TASB le pagara al doctor escogido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamiento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimadura falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opcion, puedo escoger solamente de la lista de doctores aprobados por la Alliance. Una tercera opcion, tendre que recibir aprobacion de mi ajustador antes de cambiar.

Firma

Nombre en imprenta

Fecha

Dirección: _____
domicilio

cuidad/estado/zip

Nombre de empleo:

Conroe Independent School District

Nombre del programa de contratar doctores directamente:

Political Subdivision Workers' Compensation Alliance
(*The Alliance*)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: www.pswca.org o llame a su ajustador al numero: 800.482.7276.

To be completed by employer only

Please indicate whether this is the:

- initial employee notification
 injury notification (*date of injury: ____ / ____ / ____*)

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