Panel Acknowledgement and Physician Selection

By signing this form, I accept my employer's posted medical provider panel. I understand that I must choose a provider from the panel list to give me treatment for a work injury or illness during the first 90 days of treatment. I also understand that if I get treatment from a provider that is not listed on the panel, my employer may not be required to pay for such treatment.

I also understand that I have the right to change to another provider listed on the panel if I am not satisfied with the first doctor I choose.

I choose the following medical provider to give me treatment and services for my work injury or illness:

Provider/Physician Name _____

Specialty _____

Clinic Name _____

Address _____

Phone Number _____

I have read this document. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this.

Signature _____

Printed Name _____ Date _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.