

MPN – EMPLOYEE ACKNOWLEDGEMENT

Date: _____

Dear Employee:

Please read the following information, sign and return this form to _____ as soon as possible.

Unless you predesignate a physician or medical group, your new work injuries arising on or after _____ will be treated by providers in a new Medical Provider Network; "The Care West Medical Provider Network." If you have an existing injury, you may be required to continue care under your prior MPN or to change to a provider in the new MPN, check with your claim's adjuster. You may obtain more information about the MPN from The Care West MPN, P.O. Box 277550 Sacramento, CA. 95827 Phone: 916 605-5197, or 866 849-4344. www.carewestins.com

I _____ acknowledge that I have received and understand the above information.

SIGN: _____

DATE: _____

WITNESS: _____

(Please retain a copy for your records)