PROVIDER NOTIFICATION OF A WORK-RELATED INJURY OR OCCUPATIONAL DISEASE

This form shall act as notification for workers' compensation insurance coverage. This form is to be presented to the physician's office, hospital emergency department, or other authorized provider that is treating you for your work-related injury.

This notice is to inform you that _____
(Injured employee's name)

has claimed a work-related injury or occupational disease that occurred on _____.
(Date of injury)

This employee's injury or occupational disease may be covered by Workers' Compensation Insurance through the University of Texas System. All claims are handled by CCMSI. This form does not certify compensability or guarantee payment.

For Workers' Compensation consideration **Please submit all bills and medical reports, or questions to:**	**The University of Texas System c/o CCMSI** **Cannon Cochran Management Services, Inc.** **P. O. Box 802082** **Dallas, Texas 75380** **Phone: 1.888.396.6844** **FAX: 217.477.6813**
For Provider Referrals	**Injury Management Organization (IMO)** **214.217.5939 or 888.466.6381** **FAX: 214.217.5937 or 877.946.6638** **Email: CSRNetwork@injurymanagement.com**
For Preauthorization Request	**888.645.1200 or 972.404.8133** **Fax: 888.275.9946**

_____ _____
Supervisor or Authorized Department Delegate **Date**