**California Medical Provider Network (MPN)**

# Acknowledgement Form

I have received the information that tells me how to obtain medical care within the

GBCARE Platinum MPN, MPN Identification Number 2470.

I understand that if medical care is needed for a work-related injury I must be treated by an approved doctor to qualify for benefits. Approved doctors are either a physician in the Medical Provider Network or my predesignated personal physician.

In case of an emergency, I understand that I should call 911 or go to the closest emergency room.

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(Signature) (Date)

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(Printed Name)

I live at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street Address)

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 (City) (State) (Zip Code)

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Red de Proveedores Médicos (MPN) de California**

# Formulario de acuse de recibo

He recibido la información que me dice cómo obtener el cuidado médico dentro del Número de identificación de MPN 2470, GBCARE Platinum MPN.

Entiendo que si necesito atención médica por una lesión relacionada con el trabajo, la misma debe ser tratada por un médico aprobado para tener cobertura de los beneficios. Un médico aprobado puede ser un médico de la Red de Proveedores Médicos o mi médico personal predesignado.

En caso de emergencia, entiendo que debo llamar al 911 o dirigirme a la sala de emergencias más próxima.

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(Firma) (Fecha)

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(Nombre en letras de imprenta)

Vivo en \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Dirección, calle)

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 (Ciudad) (Estado) (Código postal)

Nombre del empleador \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_