Texas Health Care Network (HCN)
Employer Verification Form

Insured Name (Print or Type): ____

Employer Name: ____

Mailing Address: ____

Employer Email Address: ____

PMA Policy & Account Numbers: ____

Employer Requirements:

- ❑ Employer named above has distributed the Coventry Workers' Comp Network Employee Notice and the Employee Acknowledgement Form on the Distribution Date shown below to each of its current employees located in the Network Service Area.
- ❑ Employer named above has collected the signed Employee Acknowledgement Forms and is keeping such forms on file as required under Texas law.
- ❑ Employer named above has documented the recipients and method used to distribute the Coventry Workers' Comp Network Employee Notice and the Employee Acknowledgement Form to employees.
- ❑ Employer named above will also distribute the same Coventry Workers' Comp Network Employee Notice and Employee Acknowledgement Form to each new employee hired after the Distribution Date shown below.
- ❑ In addition, the Employer named above will provide a copy of the Coventry Workers' Comp Network Employee Notice to an injured employee at the time that it receives active or constructive notice of an injury.

Distribution Date (MM/DD/YYYY): ____

Name of Employer Representative (Print or Type): __________________________________

Title: ___________________________________ Phone Number: _________________________

By signing below, Employer Representative acknowledges that the Employer Requirements for HCN enrollment have been completed.

Signature of Employer Representative: ____

Signature Date: _________________________

Return this completed Verification Form to your PMA CSM/CAM