City of MEMPHIS

Choice of Medical Provider Form

(Supervisor/OSHA Coordinator completes form and employee signs prior to visit)

INITIAL TREATMENT/MINOR-EMERGENCY: **(Please select one facility)**

OCCUPATIONAL MEDICINE:

Concentra Medical Center (8a-5p M-F)
2831 Airways Building A, Suite 102
Memphis, TN 38132
(901) 348-0200 Fax: (901) 348-0046

Honeycomb Medical Group (8a-4:30p M-F)
2829 Lamar Avenue
Memphis, TN 38114
(901) 345-6700 Fax (901) 345-6755

Concentra Medical Center (8a-5p M-F)
3965 S. Mendenhall Rd, Suite 6 Bldg. G
Memphis, TN 38115
(901) 365-1800 Fax: (901) 365-1862

MINOR MED CLINICS:

Methodist: Injuries Only/No Exposures)

Methodist Minor Medical (8a-6p M-S)
8071 Winchester & 8095 Club Parkway
Memphis, TN 38125 Cordova, TN 38016
(901) 756-6056 Fax: 624-0702 (901) 758-6035 Fax: 758-6029

Methodist Minor Medical (8a-8p M-Sun)
1803 Union Avenue
Memphis, TN 38104
(901) 722-3152 Fax: (901) 722-3129

Baptist: (Injuries Only/No Exposures)

Baptist Minor Medical Center (8a-5p M-F; 8a-2p S&S)
670 N. Germantown Parkway, Suite 18 (Trinity Commons)
Cordova, TN 38018
(901) 753-7686 Fax: (901) 759-9968

Facility Selected/Address:_____ **Employee Name:** _____

Type of Injury:_____ **DOI:**_____ **Time of Injury:** _____

Division:_____ **Department:**_____ **Job Title:** _____

Supervisor/OSHA Name/Signature: _____

It is a crime to knowingly provide false, incomplete, or misleading information to any party to an on-the-job injury transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits. Payments are not allowed for injury or claims stemming from, but not limited to falsifications of documents, and/or giving false statements. If you have questions, contact the OJI Coordinator at 901-636-6459. Also, each Division has an OSHA Coordinator for EE assistance.

I understand and agree that in the event benefits are paid for charges incurred by an employee as a result of accidental bodily injury or disease sustained by such employee, the employee shall reimburse the City OJI Office to the extent of such benefit payments (1) out of any recovery (whether by settlement, judgement, or otherwise) made against any person or organization responsible for causing such injury or disease, and the City OJI Office shall have a lien upon any recovery received from such injury or disease; (2) but in no event shall such employee be required to make reimbursement in an amount exceeding the recovery received by him/her against the person or organization responsible for causing the injury or disease. I must notify the City's OJI Office, Third Party Administrator, or the City Attorney's Office that a claim or lawsuit has been filed against the third party and/or the third party's insurance company within thirty days of the filing of said action. I agree by signature of this agreement that failure to notify the City of legal representation and/or acceptance of any settlement amount could result in the City's reimbursement being deducted from any wages/salaries.

Employee signature:_____ **Date:** _____

*A copy of this form must be given to the employee to take to the medical facility and sent to TPA via fax at 859-280-4803.
* If specialty care is needed, employee must IMMEDIALTELY contact TPA for instructions and authorization.
*Authorization and/or payment for an initial visit with a health care provider does not deem an on-the-job injury compensable until a final determination is made by the TPA. In the event the OJI is not deemed compensable, the employee will be personally responsible for all future treatment.

Form updated as of 03/25/2024