***NOTE: If you are injured at work a Report of Injury form must be completed on the day the injury occurs. Fax the completed form to Cathy Coppola at 570-296-3172. You must also notify your principal, supervisor, or school nurse of the injury. If you have any questions regarding this procedure, please contact Cathy at 570-296-1806.

UPMC WorkPartners
Providing Health & Productivity Solutions

REPORT OF INJURY

Delaware Valley School District, 236 Route 6 and 209
Employer's Name and address

Date

Milford PA 18337 Pike
City **State** **Zip** **County**

Employer's Phone (570) 296-1806

Injured Worker's Last Name **First Name** **Middle**

Recur/New injury Date

Home street Address

Home Phone Number

City **State** **Zip** **County**

Marital Status

☐☐ am/pm
Time Work Began

Social Security Number

____/____/____
Date of Birth

____/____/____
Date of Hire

Occupation

Full/Part-Time

If Part-Time, Days Worked
☐Mon ☐Tues ☐Wed ☐Thur ☐Fri ☐Sat ☐Sun

Name of Other employer

Hourly Rate

Supervisor

Supervisor Number

____/____/____
Date of Incident

☐☐ am/pm
Time

____/____/____
Date Reported

☐☐ am/pm
Time

Did incident occur on employer's premises: ☐Yes ☐No **Where:**

Performing regular job at the time of incident: ☐Yes ☐No

Losing Time: ☐Yes ☐No **Last Day worked:** ____/____/____

Description of Incident (who, what, when, where, how and why)

List of body parts injured:

Prior Injures and with what employer:

Treatment Sought and with whom:

Name and phone number of witnesses:

Remarks:

Report Taken by: **Date:** **Time:**

WorkPartners

Delaware Valley School District - Milford (18337)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy:WC100-0007268-2015A
Policy Effective Date:07/01/2015

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Name	Address	Scheduling	Area of Specialty
Milford Urgent Care	111 E. Catherine Street Suite 130 Milford, PA 18337	570-409-9700	Occupational Medicine
Lake Region Urgent Care	103 Spruce Street Hawley, PA 18428	570-390-4545	Occupational Medicine
PMC Physician Associates General Surgery	447 Office Plaza, 200 Plaza Court Suite B East Stroudsburg, PA 18301	570-426-2301	General Surgery
St. Luke's Neurology of Monroe County	3 Parkinson Road East Stroudsburg, PA 18301	570-424-1102	Neurosurgery
Mountain Valley Orthopedics	600 Plaza Court Suite C East Stroudsburg, PA 18301	570-421-7020	Orthopedic Surgeon
Scranton Orthopedic Specialist	334 Main Street Dickson City, PA 18519	570-307-1767	Orthopedic Surgeon
Pocono Eye Associates	300 Plaza Court Suite A East Stroudsburg, PA 18301	570-421-8842	Ophthalmology
One Call PT Network	Call Toll Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiro Networks	Call Toll Free for Closest Location	1-844-284-2525	Chiropractic
One Call Care Management	Call Toll Free for Closest Location	1-844-284-2525	MRI
Express Scripts	Call Toll Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

WorkPartners

WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of Delaware Valley School District,
(employer)
certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to WorkPartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to WorkPartners, only place in the employee file.

WorkPartners

EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee' s Signature — Date

Employee' s Name (Print) — Employee Number

Delaware Valley School District

Employer — Department

Witness' Signature — Date

Fax this form to WorkPartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to WorkPartners, only place in the employee file.

UPMC WorkPartners

Part of UPMC Insurance Services Division

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, or my designated representative, hereby authorize the use and disclosure of my personal health information upon request by UPMC Benefit Management Services d/b/a Work Partners, its successors, assigns, or designees (hereinafter Work Partners} from all claims processors, providers, and insurers contracted by my employer including, but not limited to, those who administer my employer's Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, and Employee Assistance Program (EAP).

I authorize the above persons or organizations, any medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, and claims administrator, and my employer(s) to disclose or furnish to Work Partners, or its authorized representatives, my personal health information (including physical, mental health, alcohol, substance abuse, and HIV-related Information), by way of inspection or copying of all medical records (including consultation, examination, testing, diagnosis. prognosis, physical therapy or treatments, prescriptions or medication, office records or notes, reports, correspondence, x-ray films, MRI's, CT Scans, diagnostic studies, photographs, slides, bills, and psychiatric and drug or alcohol treatment). This authorization also includes any such records or information In your possession which may have been sent to you by another health care provider(s), facility, or person(s).

I understand information received pursuant to this authorization will be utilized by Work Partners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled pursuant to the laws of Pennsylvania. I further understand that treatment, payment for treatment, and benefits may be conditioned upon this authorization.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

This authorization shall be valid for two years from the date of execution. I understand I have a right to receive a copy of this authorization and that I may revoke this authorization at any time before its expiration date by notifying Work Partners in writing, but the revocation will not have any effect on any actions a party took before revocation was received. I further understand that my personal health information may be released to others in accordance with the terms of this release. Redisclosure of my health information is not the responsibility or liability of Work Partners nor is redisclosed information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

First Name:	Last Name:
Date of Birth:	Social Security Number:
Street Address:	
City, State and Zip:	Telephone No.:
Facility and Department:	

I certify that all of the information is, to the best of my knowledge, true, correct, and complete. Please fill in the above information and sign and return this form by fax to 412-454-8717 or by mail to Work Partners, P.O. Box 2971, Pittsburgh, PA 15230.

Employee Signature Date

Signature of Designated Representative who has Authority to sign on Behalf of Employee (if applicable) Date

WorkPartners

Provider Information: please use additional sheets of paper as needed

Primary Care Physician Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

X-Rays/MRI Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

_____

Employee Name (print) Date

_____

Employee Signature

UPMC WorkPartners

Part of UPMC Insurance Services Division

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, or my designated representative, hereby authorize the use and disclosure of my personal health information upon request by UPMC Benefit Management Services d/b/a Work Partners, its successors, assigns, or designees (hereinafter Work Partners} from all claims processors, providers, and insurers contracted by my employer including, but not limited to, those who administer my employer's Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, and Employee Assistance Program (EAP).

I authorize the above persons or organizations, any medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, and claims administrator, and my employer(s) to disclose or furnish to Work Partners, or its authorized representatives, my personal health information (including physical, mental health, alcohol, substance abuse, and HIV-related Information), by way of inspection or copying of all medical records (including consultation, examination, testing, diagnosis. prognosis, physical therapy or treatments, prescriptions or medication, office records or notes, reports, correspondence, x-ray films, MRI's, CT Scans, diagnostic studies, photographs, slides, bills, and psychiatric and drug or alcohol treatment). This authorization also includes any such records or information In your possession which may have been sent to you by another health care provider(s), facility, or person(s).

I understand information received pursuant to this authorization will be utilized by Work Partners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled pursuant to the laws of Pennsylvania. I further understand that treatment, payment for treatment, and benefits may be conditioned upon this authorization.

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First Name:	Last Name:
Date of Birth:	Social Security Number:
Street Address:	
City, State and Zip:	Telephone No.:
Facility and Department:	

I certify that all of the information is, to the best of my knowledge, true, correct, and complete. Please fill in the above information and sign and return this form by fax to 412-454-8717 or by mail to Work Partners, P.O. Box 2971, Pittsburgh, PA 15230.

Employee Signature Date

Signature of Designated Representative who has Authority to sign on Behalf of Employee (if applicable) Date

WorkPartners

Provider Information: please use additional sheets of paper as needed

Primary Care Physician Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

X-Rays/MRI Provider Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number:

_____

Employee Name (print) Date

_____

Employee Signature

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 866.759.6146.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

(enter in PA field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

Group #: KYHA

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

Delaware Valley School District

UPMC WorkPartners
Providing Health & Productivity Solutions

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

EXPRESS SCRIPTS®