WorkPartners

Report of Injury

Employer's Name and Address			Date
City, State, ZIP, County			Emp. Phone
Injured Worker's Last Name, First Name, Middle Initial			Recur/New Injury Date
Home Street Address			Home Phone No.
City, State, ZIP, County		Marital Status	Time Work Began ❑ a.m. ❑ p.m.
Social Security Number	Date of Birth		Date of Hire
Occupation			
❑ Full-time ❑ 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	Time ❑ a.m. ❑ p.m.	Date Reported	Time ❑ a.m. ❑ p.m.
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 injuries and with what employer:			
Treatment sought and with whom:			
Name and phone number of witnesses:			
Remarks:			
Reported by:		Date:	Time:

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company, or files an application for insurance or statement of claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties.

U.S. Steel Tower, 600 Grant Street, 8th Floor, Pittsburgh, PA 15219 •workpartners.com

UPMCHP WC COMM IMJURY RPRT 17WP2017 (MJA) 10/9/17 PDF

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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
Policy Effective Date:07/01/2021

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
LVPG Occupational Medicine - Tannersville	2838 Route 611 Health Center at Tannersville Tannersville, PA 18372	570-476-3336	Occupational Medicine
Lake Region Urgent Care	273 Grandview Ave, Unit 4 Honesdale, PA 18431	570-390-4545	Urgent Care
LVPG General & Trauma Surgery - Plaza Court	447 Plaza Ct, Bldg 500, Ste B East Stroudsburg, PA 18301	570-426-2301	General Surgery
Commonwealth Health Neurosurgery - Dr Carlo de Luna MD	545 N River St, Ste 240 Wilkes-Barre, PA 18702	570-706-2620	Neurosurgery
Coordinated Health Orthopedic Institute - East Stroudsburg	505 Independence Rd, Ste A East Stroudsburg, PA 18301	570-369-5001	Orthopedics
Mountain Valley Orthopedics - East Stroudsburg	600 Plaza Ct, Ste C East Stroudsburg, PA 18301	570-421-7020	Orthopedics
Mountain Valley Orthopedics - Milford	100 Wheatfield Drive, Ste 2 Milford, PA 18337	570-421-7020	Orthopedics
Pocono Eye Associates - East Stroudsburg	300 Plaza Ct, Ste A East Stroudsburg, PA 18301	570-497-5071	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

Panel updated: 9/22/2021

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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 _____,
(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.

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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 _____

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.

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WORKERS' COMPENSATION AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Employee's Full Name	**Claim Number**
Address	**Date of Birth**
City, State Zip Code	**Telephone Number**
Employer	

I hereby authorize the release of my protected health information (PHI) or other information relevant or potentially related to the injury or condition indicated below to WorkPartners, on behalf of UPMC Benefit Management Services, Inc. or UPMC Health Benefits, Inc., as applicable, its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.

Description of Injury or Condition: _____

Date of Injury or Condition: _____

Such disclosure may contain PHI or other information related to my Workers' Compensation medical condition or other condition(s) noted above, including, but not limited to, medical records, patient files, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings, provided all requests for this information are in writing.

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation, provided that such duration shall not exceed two years from the date of the signature on the following page.

I understand that WorkPartners may be required to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including but not limited to Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I certify that all of the information that I have provided is, to the best of my knowledge, true, correct, and complete.

WorkPartners

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing (*see* #2 on the next page), but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners.
- I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please return this completed and signed form by fax to 412-454-8717 or by mail to WorkPartners, PO Box 2971 Pittsburgh, PA 15230.

1. Type of records to be released (check all that apply):

☑ Inpatient
☑ Outpatient
☑ Diagnostic testing
☐ Other: _____
☑ Emergency department
☑ Physician/Office
☑ Physical therapy

Unless you check the box(es) immediately below, no information about alcohol/substance abuse, HIV/AIDS or behavioral health will be disclosed:

☐ **YES**, disclose information related to alcohol/substance abuse
☐ **YES**, disclose Information Related To HIV/AIDS
☐ **YES**, disclose Behavioral Health Information

2. I may revoke this authorization by notifying:

UPMC Insurance Services Division
Attn: Chief Privacy Officer
600 Grant Street
Pittsburgh, PA 15219
HealthPlanCPO@upmc.edu

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Employee	**Date of Employee's Signature**	**Employee's Date of Birth or Claim Number**

OR, if applicable –

Signature of Parent, Legal Guardian or Authorized Representative	**Date of Parent, Legal Guardian or Authorized Representative's Signature**	**Description of Authority to Act for the Employee (i.e., Parent, Legal Guardian or Authorized Representative)**

A copy of this completed, signed and dated form must be given to the member or other signator.

Official Use Only		
Received	**Processed By**	**Log #**

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Provider Information: please use additional sheets of paper as needed

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Primary Care Physician Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Diagnostic Testing Provider: _____

Address: _____

_____

Telephone Number: _____

Patient Name (print): _____

Patient Signature: _____

Date of 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

_____

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.