

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.
Email Address		
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



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:

Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th Fl
Harrisburg, Pennsylvania 17121-0750
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.

Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230



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: 07/01/2025

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.

Please contact your Claims Adjuster for any specialty need not listed on this panel.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
St Luke's Care Now - Pocono Summit (All Locations)	174 Harvest Ln Pocono Summit, PA 18346	272-639-5430	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	545 N River St, Ste 200 Wilkes-Barre, PA 18702	570-706-2620	Neurosurgery
Dr David J Caucci MD	3202 Lake Ariel Hwy Honesdale, PA 18431	570-647-0001	Orthopedics
LVPG Orthopedics and Sports Medicine-Independence Road	505 Independence Rd, Ste A East Stroudsburg, PA 18301	610-402-8900	Orthopedics
Mogerman Orthopedic Group	27 A Woodlands Dr Waymart, PA 18472	570-488-9880	Orthopedics
Pocono Eye Associates - East Stroudsburg	300 Plaza Ct, Ste A East Stroudsburg, PA 18301	570-421-8842	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



**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.



**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.



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 | ☒ Emergency department |
| ☒ Outpatient | ☒ Physician/Office |
| ☒ Diagnostic testing | ☒ Physical therapy |
| ☐ Other: _____ | |

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 #



Provider Information: please use additional sheets of paper as needed

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

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al emitir 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 OOI. 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 #: KVHA

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
Prescribing Health & Productivity Solutions



Participating Retail Network Pharmacies

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

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 medications to a patient.



EXPRESS SCRIPTS