Human Resources Office

Radnor Township School District
Administration Building
135 South Wayne Avenue
Wayne, PA 19087
Phone: 610-688-8100 • Fax: 610-386-6135

TO: All Employees of Radnor Township School District

FROM: Jessica King, Benefits Coordinator

DATE: June 1, 2023

RE: Workers Compensation Carrier: Eastern Alliance

If you have a work-related injury or illness, please report it to your supervisor *immediately.* Even if you do not initially feel that you need medical attention, it is in your best interest to report the injury and complete the claim documents. Should your condition worsen in the coming days, your claim will already be recorded, and you can proceed with treatment. Remember, as a valued employee of the district, your health and wellbeing are important to us!

Complete the forms listed below and return them to the Benefits Coordinator:

- *Eastern Alliance Insurance Group Claim Reporting Worksheet -to* be completed by the employee or their designee.
- *Employee Acknowledgement of Rights and Duties* -to be signed by the employee.
- *Authorization to Release Medical Information -to* be completed and signed by the employee to ensure prompt processing of your claim, please submit the above documents to the Benefits Coordinator as soon as reasonably possible.

Keep the documents listed below for the duration of injury/illness:

- *Designated Health Care Providers* (posted panel) -Employees must treat with one of the physicians listed for the first ninety (90) days from the date of the first visit. For non-emergencies, choose from the Occupational Medicine providers on the panel. For emergency care, you should go to the nearest hospital for dial 911.
- *Keyscripts Prescription Information* -If a panel physician prescribes medication, please take this information to a pharmacy near you to get your prescription filled.

If you have questions about the claim process or need assistance completing the forms, contact the Benefits Coordinator at 610.688.8100, ext. 6057.

PLEASE DISCARD ALL PRIOR VERSIONS OF WORKERS' COMPENSATION CLAIM FORMS

The Pennsylvania Bureau of Workers' Compensation requires that the following information be provided to every employee at the time of hire and immediately after the injury, or as soon thereafter as possible under the circumstances of the injury. If the employee's injuries are so severe that emergency care is required, the information shall be given as soon after the occurrence of the injury as is practicable. The information must be printed on paper no smaller than 8 1/2 × 11 inches and in font no smaller than 11 point.

Workers' Compensation Information

(1) 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.

(2) Benefits are required to be paid by your employer when 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, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

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

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania: (800) 482-2383
Telephone number outside of this Commonwealth: (717) 772-4447
TTY (800) 362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA Keyword: workers comp.

Eastern Alliance Insurance Group Claim Reporting Worksheet
24/7 Teleclaim: 1.800.336.3658 / Online: www.easternalliance.com
DO NOT FAX THIS FORM TO US

General Information

Date of loss/injury: _____ Submitter name and title: _____

Submitter phone #: (____) _____

Who is the contact person for the claim?: _____

First Report of Injury distribution:

If you want the First Report of Injury **emailed**, please provide an email address (you can provide up to 2):

_____ _____

If you want the First Report of Injury **faxed**, please provide a fax number (you can provide up to 2):

(____) _____ (____) _____

Policyholder Information

Employer mailing address: _____

County: _____

Physical address if different than mailing address: _____

County: _____

Location code/name where accident occurred: _____

Policy number: _____

Injured Worker Information

Injured Worker's Social Security Number: ____-____-_____

Injured Worker's name: _____

Injured Worker's mailing address: _____

Injured Worker's phone # with area code: (____) _____ Gender: _____ Marital status: _____

Birth date: ____/____/_____ # of dependents: _____

Hire date: ____/____/_____ State of hire: _____ Job title: _____

Employment status: _____ Was the injured worker paid full wages for the day of injury?: _____

Supervisor name and phone #: _____ (____) _____

Accident Information

Did the accident occur on the employer's premises?: _____

If no, provide the accident site's name/address:_____

Time of Injury: _____ Time shift began: _____

Did the injured worker lose time as a result of the injury?: _____

Date last work or # of days off: _____ First day off of work: _____

Has the injured worker returned to work (RTW)? _____ Date Returned: _____

If RTW, is the injured worker working with or without restrictions? _____

If working with restrictions: Will the injured worker lose any wages/hours/benefits?:_____

Please list any work restrictions: _____

_____

Date employer notified of the injury: _____ Name of person notified: _____

Did the injury result in death?: _____

Nature of injury: _____

Body part(s) injured: _____

If applicable: Right/Left/Both (circle one) Finger/Toes (which finger or toe): _____

Cause of injury: _____

Description of accident: _____

Were safeguards or safety equipment provided?: _____

Witness name and phone #: _____ (___) _____

Witness name and phone #: _____ (___) _____

Treatment Information

What type of initial treatment did the Injured Worker receive? _____

Was there emergency medical/ambulance service provided at time of loss? _____

Name, address, phone # of medical provider/facility: _____

_____ (___) _____

Physician name: _____

Follow-up treatment information: _____

_____

Was a list of medical providers (panel) given to the Injured Worker? _____

Additional Information

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Workers' Compensation is designed to provide wage loss benefits and payment for reasonable medical care for one who is injured on the job.

Remember: It is important to tell your employer about your injury immediately.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you must select. You must obtain treatment from one or more of these providers for ninety (90) days from the date of your first visit.

If you have a medical emergency, you may go to the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you seek treatment from a non-panel provider within the first ninety (90) days following your first visit, your employer will not have to pay for those services.

In the event invasive surgery is prescribed by a physician or other health care provider on your employer's panel, you are entitled to a second opinion from any other health care provider of your choice. If the opinion differs from the one provided by the panel provider, you may choose which course of treatment to follow. However, the second opinion must state a specific course of treatment. If you choose the treatment offered by the second opinion you must receive that treatment from a panel provider for a period of ninety (90) days from the date of the visit to the provider of the second opinion.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of services rendered if such services are determined to have been unreasonable or unnecessary. The non-panel provider must provide an initial report to the employer, within ten (10) days of the first treatment and every thirty (30) days thereafter, as long as the treatment continues.

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

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

_ *At Time of Hire* _ *After an Injury*

Employee Signature_____ Date_____

Witness Signature_____ Date_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I hereby AUTHORIZE all healthcare providers to use and disclosure my Protected Health Information (PHI) as described in this authorization. A photocopy of this Authorization is as valid as the original.

PATIENT IDENTIFICATION INFORMATION

Account or medical record number: _____ Claim No.: _____

Patient's Full Name: _____
Last First Middle

Address: _____

Social Security No.: _____ Date of Birth: _____

Name and address of recipient: Eastern Alliance Insurance Group
P.O. Box 83777
Lancaster, PA 17608-3777

Release

The purpose of use or disclosure of patient information is for my workers' compensation claim.

I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: hospital and emergency operational logs, outpatient records; medical reports; clinical notes; nurses' notes; physical therapy records; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; bills for services; payments received; and any other relevant and material information in the health care provider's possession. This authorization includes the release of documents in the possession of the healthcare provider whether or not created in your office or by another healthcare provider.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I authorize the release of the information listed below, which requires specific consent under federal law: **(check all that apply)**

☐Substance Abuse ☐Mental Health Treatment ☐HIV/AIDS related testing

I also agree that any and all of my health care providers may discuss the details of my medical information with the representatives of the above named recipient. However, the health care provider will not condition treatment on the completion of the authorization.

Conditions

I understand that information released in response to this authorization may be used or disclosed to administer, determine and/or litigate my claim. I acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Subpart E of the Regulations promulgated by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to the privacy of individually identifiable health information.

I understand that this authorization is valid until my case has been closed and for up to one year from the date of closure. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Eastern. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I have read this Authorization and understand that I can retain a copy.

_____ _____
Signature of Patient Date

_____ _____
Signature of the patient's personal representative or patient's guardian (if the patient is a minor or incapacitated adult Date

_____
Printed name, address, phone number of guardian

Description of Authority to Act for Patient: _____

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

KEYSCRIPTS

Live-Operator Support 866.446.2848
Email info@keyscriptsllc.com
Visit keyscriptsllc.com
Fax 717.732.9467

Dear Injured Worker:

The attached temporary KeyScripts Prescription Benefit Card will authorize you to obtain prescription medications related to your work injury, with no out-of-pocket expense, **but you must call to activate the card before taking it to the pharmacy.** The call takes only a few minutes. You will be asked for your name, date of birth, employer's name and telephone number, and your date of injury, so please have this information available when you call.

CALL 866.446.2848 TO ACTIVATE YOUR CARD NOW

YOUR ACCOUNT NAME IS: EASTERN ALLIANCE

Write your name and Employee ID number (provided to you during card activation) in the spaces provided on the card. Your card will be immediately activated after your call, and you may then take it to your pharmacy to fill your work injury prescription(s). *NOTE: There may be limitations on how much of your prescription can be filled, based on your employer's prescription benefit plan.*

Do not attempt to fill any prescription other than your work injury prescription using the KeyScripts card. Avoid filling any prescription related to your work injury directly at the prescribing physician's office, as most physicians do not accept prescription benefit cards similar to KeyScripts' for billing purposes.

You may visit your KeyScripts network pharmacy of choice, which includes all of the major retail pharmacies, such as CVS, Rite Aid, Target, Walgreens and Walmart. **Need help finding your nearest network pharmacy? Call KeyScripts at 866.446.2848.**

Your temporary KeyScripts Prescription Benefit Card contains important claims and customer service information for you and your pharmacist. After activation, present the card to your pharmacist when filling any prescription related to your work injury. You will receive a permanent card in the mail shortly.

KEYSCRIPTS For customer service, call 866.446.2848 **Bin #: 009430** **Group ID: EAST0030** ProCare Rx **Employee Name:**_____ **Employee ID:** _____ ***Workers' Compensation Prescription Benefit Card***	**To the Employee:** Present this card to your pharmacy of choice for any prescription drug related to your worker's compensation injury. This card is for identification purposes only, and your pharmacist may require additional/photo identification at time of fill. Unauthorized or fraudulent use of this card is punishable by law. We reserve the right to revoke this card at any time. **To the Pharmacy:** Submit claims via the ProCare System only for the person for whom the prescription was written. ProCare RX 1267 Professional Parkway, Gainesville GA 30507 **Pharmacy Help Desk 1.800.277.1657**

Radnor Township School District - Wayne (19087)
(4/10/2023)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

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 ensure 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 physician's 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 CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-855-572-3926 FOR ASSISTANCE IN SCHEDULING PHYSICAL/OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITIATION OR SEND THE REFERRAL FORM TO
easternreferrals@medrisknet.com

Name	Address	Scheduling	Area of Specialty
Worknet Occupational Medicine	170 N Henderson Rd Ste 306 King of Prussia, PA 19406	610-337-1558	Occupational Medicine
Patient First	400 E Germantown Pike Norristown, PA 19403	610-994-0063	Occupational Medicine
Concentra Medical Center	625 N Pottstown Pike Exton, PA 19341	610-903-0640	Occupational Medicine
Concentra Medical Center	850 Germantown Pike Plymouth Meeting, PA 19462	610-275-3884	Occupational Medicine
Tower Health Urgent Care - Villanova	635 Conestoga Rd Villanova, PA 19085	610-710-4444	Urgent Care
Patient First	133 Lancaster Ave Devon, PA 19333	484-581-2990	Urgent Care
Im Health - Urgent Care	1st Floor 372 W. Lancaster Avenue Wayne, PA 19087	610-688-8807	Urgent Care
Penn Orthopaedics at Radnor	145 King of Prussia Rd 3rd Floor, Suite 305 South Radnor, PA 19087	215-662-3340	Orthopedics
Premier Orthopaedic & Sports Medicine Associates LTD Sara Lu-Min Low	2004 Sproul Rd Ste 306 Broomall, PA 19008	610-353-0800	Orthopedics
Suburban Surgical Specialists	2705 Dekalb Pike Ste 309 Norristown, PA 19401	610-277-6131	General Surgery
Wills Eye Physicians	901 E 8th Ave Ste 101 King of Prussia, PA 19406	610-265-1188	Ophthalmology
Ivy Rehab	555 Lancaster Avenue Radnor, PA 19087	484-577-8950	Rehabilitation

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Name	Address	Scheduling	Area of Specialty
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Pharmacy
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Durable Medical Equipment
MedRisk	Call Toll Free for Scheduling	1-855-572-3926	Physical and Occupational Therapy Chiropractic Care
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI
Carlisle Medical, Inc.	Call Toll Free for Closest Location	1-800-553-1783	Durable Medical Equipment
Homelink	Call Toll Free for Closest Location	1-800-571-2943	Durable Medical Equipment