

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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Social Security Number	Date of Birth	Date of Hire	
Occupation			
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	If Part-Time, Days Worked <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		Name of Other Employer
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date Reported	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Did incident occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Where:			
Performing regular job at the time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Losing time? <input type="checkbox"/> Yes <input type="checkbox"/> 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 AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION**

<hr/> Employee's Full Name	<hr/> (CLAIM NUMBER UNKNOWN AT TIME OF SIGNING) Claim Number
<hr/> Address	<hr/> Date of Birth
<hr/> City, State Zip Code	<hr/> Telephone Number
<hr/> TRINITY AREA SCHOOL DISTRICT Employer	<hr/>

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):
- | | |
|--|--|
| <input checked="" type="checkbox"/> Inpatient | <input checked="" type="checkbox"/> Emergency department |
| <input checked="" type="checkbox"/> Outpatient | <input checked="" type="checkbox"/> Physician/Office |
| <input checked="" type="checkbox"/> Diagnostic testing | <input checked="" type="checkbox"/> Physical therapy |
| <input type="checkbox"/> 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)
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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 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.



**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
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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.



Trinity Area School District - Washington (15301)
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: WC100-2033090
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.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Washington Health System Occupational Medicine - Washington	95 Leonard Ave, Bldg 1, Ste 401 Washington, PA 15301	724-223-3528	Occupational Medicine
St Clair Occupational Medicine (use Urgent Care after hours)	2000 Oxford Dr, Ste 100 Urgent Care: (412) 942-8800 Bethel Park, PA 15102	412-942-7115	Occupational Medicine
MedExpress Urgent Care - Washington All Locations - medexpress.com	460 Washington Rd, Ste 7 Washington, PA 15301	724-225-3627	Urgent Care
Angott Surgical Associates	88 Wellness Way Washington, PA 15301	724-222-9500	General Surgery
*Tri-State Neurosurgical Associates - UPMC - Coraopolis	1600 Coraopolis Heights Rd, Ste G UPMC West Coraopolis, PA 15108	888-234-4357	Neurosurgery
*Orthopaedic Specialists - UPMC - Washington/100 Trich Dr	100 Trich Dr Washington, PA 15301	877-471-0935	Orthopedics
Washington Health System Orthopedics & Sports Medicine	95 Leonard Ave, Ste 202 Washington, PA 15301	724-206-0610	Orthopedics
Southwestern Pennsylvania Eye Center - Washington	750 E Beau St Washington, PA 15301	724-228-2982	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

accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.

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 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

>> To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of \$150. This form is valid for up to 30 days from date of injury (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 WC

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

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.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies

workpartners



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