Schuylkill Intermediate Unit #29
Schuylkill Technology Center
Employee Injury Packet

Employee Name: _____

Date of Injury: _____

Supervisors Name: _____

Witness to the injury: _____

Employee Injury Checklist:

☐Receive First Aid/Evaluation from the building Nurse and/or other medical personnel. *If you are in need of further medical attention - contact Human Resources to schedule your appointment.*

Amanda Ward, Human Resources Coordinator
570-544-9131 ext.1249 OR warda@iu29.org

☐Notify your direct supervisor and Human Resources of ALL injuries immediately.

☐Follow the step by step instructions enclosed in this packet.

☐Complete and return the packet to the Human Resources Department **within 24 HOURS.**

Section One

Instructions: Upon injury Employee is to complete this section in its entirety.
Please sign all releases/notices and complete the injury report form with as much detail as possible. If applicable, provide the witness statement form to anyone who was present for the injury. Please make sure the witness form is completed and returned with your packet.

Forms included in this section:

- Medical Records Release
- Employee's Rights and Duties
- Workers Compensation Notice
- Employee- Statement of Injury or Illness

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MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

HIV/AIDS	Behavioral health	Drug and alcohol	Genetic history
_____	_____	_____	_____

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ _____

Signature of individual | Date

_____ _____

Social Security number | Date of birth

_____

Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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INSURANCE

EMPLOYEE'S RIGHTS & DUTIES UNDER SECTION 306 (F.1) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

During the 90-day period, you may change from one designated physician or health care provider on the list to another physician or health care provider on the list, and the treatment will be paid for by the employer.

If the designated physician or health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider however, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

If the employer-designated physician or health care provider recommends invasive surgery, you are permitted to obtain a second opinion from a non-designated physician or health care provider. Your employer will pay for the cost for this opinion. If this opinion differs from the opinion of the designated physician or health care provider and provides a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment however must be provided by a designated physician or health care provider for 90 days from the date of the visit to the non-designated physician.

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or 1-717-783-5421.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND THE ABOVE RIGHTS AND DUTIES.

Employee name	Employee signature	Date
Supervisor name	Supervisor signature	Date

IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.

Supervisor name	Supervisor signature	Date

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INSURANCE

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of six or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.l)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least six providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties.
If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

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INSURANCE

REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least six health care providers on the list, but there may be more than six listed.
2. At least three of the health care providers on the list must be physicians.
3. No more than four of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER

1-800-482-2383 (long-distance calls inside PA)
1-717-772-4447 (local and calls outside PA)

SCHUYLKILL IU #29/SCHUYLKILL TECHNOLOGY CENTER
"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION
[To be completed by Employee]

Name (First, Last)	Date of Birth / /	Social Security Number
Address: (Street, City, State, Zip)		
Phone Number(s): Home: ( ) Other: ( )		
Job Title:	Department:	Shift:
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:	

Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	Worked Until End of Shift ☐YES ☐ NO
Accident was reported to:			

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ **Arm**	☐ **Face**	☐ **Groin**	☐ **Internal Organs**	☐ **Neck**	☐ **Wrist**
☐ **Back**	☐ **Finger**	☐ **Hand**	☐ **Leg**	☐ **Elbow**	☐ **Other (describe)**
☐ **Eye**	☐ **Foot/feet**	☐ **Head**	☐ **Knee**	☐ **Stomach**	

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.
Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act165.

Employee Signature: **Date:**
Original Signature Required.

"WITNESS" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]			
Name (First) of witness	(Last)	(Middle initial)	
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:		
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	
Accident was reported to:			

Description of Accident (Describe how the injury occurred, be specific) (include body parts assumed to be injured)

Drawing of Accident:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.
Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of the law and may also be subject to criminal and civil penalties.

Witness Signature: **Date:**
Original Signature Required.

Section Two

Instructions: Provide this form to your direct supervisor to be completed. Form must be returned with the packet to the Human Resources Department.

Forms included in this section:

- Supervisor Accident Investigation Report
- Supervisor Accident Investigation Checklist

SUPERVISOR
ACCIDENT INVESTIGATION REPORT

SUPERVISOR REPORT
[To be completed by the employee's direct supervisor]

Date of Accident / /	Employee's Name (First, Last)	
Supervisor Name:	Department / Location:	

Was this the employee's usual occupation? ☐ Yes ☐ No If No, Describe. Was the employee performing a normal job task? ☐ Yes ☐ No If No, Describe. --- Do you have any reason to believe this employee's injury did *not* occur at work? ☐ Yes ☐ No If Yes, List the Reasons:	Time in occupation. ☐ Less than 1 month ☐ 1 to 5 months ☐ 6 months to 5 years ☐ More than 5 years	Treatment. ☐ First-Aid (In-House) ☐ Emergency Room (Hospital) ☐ Clinic or Doctor's Office --- Name of Clinic or Doctor:

ACCIDENT INVESTIGATION

Accident Sequence
Instructions: Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury and moving back in time, reconstruct the sequence of events that led to the injury.

❶ Injury Event
❷ Accident Event
❸ Preceding Event 1
❹ Preceding Event 2
❺ Preceding Event 3

Describe the Accident:

Injury Classification

Nature of Injury:

☐ Slip / Fall	☐ Struck By	☐ Contact with Electrical Current	☐ Fall from Elevation
☐ Strain	☐ Puncture	☐ Burn	☐ Fall from Same Level
☐ Sprain	☐ Caught in/or between	☐ Other (describe)	
☐ Struck Against	☐ Overexertion		

Type of Injury:

☐ Abrasion	☐ Crush Injury	☐ Sprain	☐ Inhalation	☐ Other: (describe)
☐ Amputation	☐ Eye - Foreign Body	☐ Puncture	☐ Dermatitis	
☐ Burn	☐ Fracture	☐ Infection	☐ Repetitive Motion	
☐ Contusion	☐ Laceration	☐ Illness	☐ Tendonitis	

Accident Sketch and/or Photograph(s) (Attach)

Witness(s) Interviews:

(1) Name:
Phone Number:
Statement:

(2) Name:
Phone Number:
Statement:

Casual Factors (Check all factors that contributed to the accident)

☐ Unsafe Act	☐ Failure to work at a safe speed/pace
☐ Failure to Follow a Standard Operating Procedure	☐ Improper body mechanics (i.e. unsafe lifting technique)
☐ Failure to Comply with Direction	☐ Unsafe work environment or condition
☐ Hazardous Work Condition	☐ Failure to obey safety policy
☐ Failure to use Personal Protective Equipment	☐ Inadequate training
☐ Improper use of Equipment and/or Machinery	☐ Horseplay
☐ Equipment Malfunction	☐ Other:

Comments:

Corrective Actions (corrective actions must be listed for all accidents)

☐ Retrain Employee (s)	☐ Use additional Protective Equipment	PROPOSED COMPLETION DATE:
☐ Implement a new or revised job procedure	☐ Install Machine Guarding	
☐ Repair or Modify Equipment or Machinery	☐ Other. (Please Describe Below)	

Comments:

Supervisor Signature: Date:

ACCIDENT INVESTIGATION

Every accident should be investigated thoroughly to determine the cause and put preventive measures in place. The investigation should be conducted as soon as possible to get the most accurate information, obtain the facts and prevent recurrence.

STEPS TO FOLLOW

1. *Receive notification of incident*
2. *Initiate the investigation*
   a. Secure the scene
   b. Form an investigative team (co-workers, maintenance, engineers, safety, etc.)
   c. Collect the facts
   d. Analyze the facts
3. *Determine if reporting to authorities such as OSHA, CDC, etc. is required*
4. *Complete required reports*
   a. Employee Incident Report
   b. Witness statement
   c. Include pictures
   d. Forward report
5. *Identify*
   a. Root cause(s)
   b. Contributing factor(s)
   c. Corrective action(s)
6. *Implement corrective action(s)*
   a. Immediate action(s)
   b. Short term
   c. Long term
7. *Educate employee(s)*

THE QUESTIONS BELOW WILL ASSIST IN DETERMINING THE CAUSATION FACTORS OF THE ACCIDENT AND POSSIBLE CORRECTIVE ACTIONS.

QUESTIONS TO ASK	IF THE CAUSES APPEAR TO BE	
	CONDITIONS	ACTIONS
WHO	was responsible for it? can give me answers? should take corrective action?	is best qualified to do it? can give me answers? can show me what was being done?
WHAT	caused it to exist? caused it to be involved?	was its purpose? other way could it be done? details could be eliminated? instructions were not followed?
WHEN	did it occur? do similar conditions occur?	should it be done?
WHERE	was it? was its source? else does it exist? can I find out?	should it be done? else is it being done?
HOW	should it be corrected? can it be avoided in the future?	is the best way to do it? can it (job or detail) be improved?
WHY	did it exist? had no one noticed and corrected it?	was it being done? was it being done this way? was it (job or detail) necessary?

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Section Three

Instructions: Take the "Employee Injury Card" with you to any scheduled Workers Compensation appointments to ensure they are appropriately billing our insurance. All other forms in this section are copies for you to retain for your records.

Forms included in this section:

- Employee Injury Card
- Schuylkill IU #29/Schuylkill Technology Center Panel of Providers
- Mitchell Script Advisor
- Employee Copy of Medical Records Release
- Employee Copy of Employee's Rights and Duties
- Employee Copy of Workers Compensation Notice

Employee Injury Card

Please reference this our insurance carrier at your appointment to ensure appropriate billing.

Encova Insurance
P.O. Box 3151
Charleston, West Virginia 25332

Employee Injury Card

Please reference this our insurance carrier at your appointment to ensure appropriate billing.

Encova Insurance
P.O. Box 3151
Charleston, West Virginia 25332

Employee Injury Card

Please reference this our insurance carrier at your appointment to ensure appropriate billing.

Encova Insurance
P.O. Box 3151
Charleston, West Virginia 25332

Employee Injury Card

Please reference this our insurance carrier at your appointment to ensure appropriate billing.

Encova Insurance
P.O. Box 3151
Charleston, West Virginia 25332

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INSURANCE

Schuylkill IU #29 – Schuylkill Technology Center

Your Workers' Compensation Insurance Carrier is:

Encova Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

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. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, 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.
5. 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.
6. 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	Phone	Area of Specialty
LVHN Occ Med Center	100 Schuylkill Medical Plaza, Suite 103 Pottsville, PA 17901	570-621-5067	Occupational Medicine
WorkPlace Health (Multiple Locations)	521 North Franklin Street Shamokin, PA 17872	570-509-2642	Occupational Medicine
Matthew C. Sophy, DO	73 Coal Street Port Carbon, PA 17965	570-622-6302	Family Practice
St. Luke's Orthopedic Care (Multiple Locations)	120 Pine Street Tamaqua, PA 18252	484-526-1735	Orthopedics
Integrated Surgical Specialists (Multiple Locations)	48 Tunnel Road, Suite 203 Pottsville, PA 17901	570-624-4777	Orthopedics
Integrated Medical Group - General Surgery	48 Tunnel Road, Suite 205 Pottsville, PA 17901	570-622-1400	General Surgery
Chawluk & Dubey, MDs	48 Tunnel Road, Suite 101 Evergreen Professional Suites Pottsville, PA 17901	570-622-2245	Neurology
Progressive Vision Institute (Multiple Locations)	201 East Laurel Blvd Pottsville, PA 17901	570-628-4444	Ophthalmology

CONVENIENT NETWORK LOCATIONS LISTED BELOW

PCS PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
PCS Diagnostic Network	Call Toll Free for Closest Location	1-888-594-4001	Diagnostic Testing
Apricus	Call Toll Free	1-877-203-9899	DME
Mitchell ScriptAdvisor	Call Toll Free for Closest Location	1-866-846-9279	Pharmacy

Panel Date: 7/21/2021

Mitchell ScriptAdvisor

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by **Encova Insurance** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: **Process through Script Care and Enter RxBIN, RxPCN and GROUP.**

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001536TC

Walmart · RITE AID · Longs Drugs · CVS pharmacy · TARGET · Walgreens · SAFEWAY

Questions?
Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International
866.221.6588
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MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

HIV/AIDS	Behavioral health	Drug and alcohol	Genetic history
_____	_____	_____	_____

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ Signature of individual

_____ Date

_____ Social Security number

_____ Date of birth

_____ Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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INSURANCE

EMPLOYEE'S RIGHTS & DUTIES UNDER SECTION 306 (F.1) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

During the 90-day period, you may change from one designated physician or health care provider on the list to another physician or health care provider on the list, and the treatment will be paid for by the employer.

If the designated physician or health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider however, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

If the employer-designated physician or health care provider recommends invasive surgery, you are permitted to obtain a second opinion from a non-designated physician or health care provider. Your employer will pay for the cost for this opinion. If this opinion differs from the opinion of the designated physician or health care provider and provides a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment however must be provided by a designated physician or health care provider for 90 days from the date of the visit to the non-designated physician.

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or 1-717-783-5421.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND THE ABOVE RIGHTS AND DUTIES.

Employee name	Employee signature	Date
Supervisor name	Supervisor signature	Date

IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.

Supervisor name	Supervisor signature	Date

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NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of six or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.l)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least six providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties.
If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

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REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least six health care providers on the list, but there may be more than six listed.
2. At least three of the health care providers on the list must be physicians.
3. No more than four of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER

1-800-482-2383 (long-distance calls inside PA)
1-717-772-4447 (local and calls outside PA)
