

INJURED EMPLOYEE CHECKLIST



Report all injuries to supervisor

(Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)



Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)



If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form



If not released to return to work, you must call your supervisor within one business day and provide:

- Physician's name, address and phone number
- Date of your next scheduled doctor appointment



Return Incident Report to your supervisor upon return or within 24 hours

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



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



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 International
866.221.6588

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* Denotes required field

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of injury: *	Policy number:	Policy name:	Case # from OSHA Log (if applicable):
Filing date:	Claim type: * ☐ Incident ☐ Indemnity ☐ Medical only		Jurisdiction:

What is your name? *	What is your job title?		
What is your telephone number? *	What is your fax number?	What is your email address?	
Are you the contact for this claim? ☐ No ☐ Yes		If no, who should we contact for additional information?	
What is the contact's phone number?		What is the contact's email?	
Is this a Federal Longshore (USL&H) claim? ☐ No ☐ Yes		Are you reporting a fatality? ☐ No ☐ Yes	Date of death: *
Date of injury/date of last exposure: *		What is your policy number? *	
What is the employee's ID type? *	☐ Employment Visa number ☐ Green Card number ☐ Passport number ☐ Social Security number		
What is the employee's name?	First: *	MI:	Last: * Suffix:
What is the employee's mailing address? Street/P.O. Box: *			
Zip: *	City: *	State: *	Country:
What is the employee's physical address? Street/P.O. Box:			
Zip:	City:	State:	Country:
What is the employee's primary telephone number?		What is the employee's alternate telephone number?	
What is the employee's regular work schedule?			

What is the employee's date of birth? *	Gender: * ☐ Male ☐ Female ☐ Unknown
Marital status: * ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common law ☐ Unknown	
What is the industrial code? *	What is the job title? *
Description of employee's job and regular duties:	

What is the employee's hire date? *		What is the state of hire for this employee?	
Employment type: ☐ Full-Time ☐ Part-Time ☐ Volunteer		Is the employee: An officer? ☐ No ☐ Yes An owner/part owner? ☐ No ☐ Yes	
What is the hourly rate of pay for this employee?		What are the number of hours worked per week for this employee?	
What is the daily rate of pay for this employee?	How many hours per day did the employee work?	How many days per week did the employee work?	
Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?			
Is the employee continuing to receive full wages? ☐ No ☐ Yes			

What is the primary work location? *			
Name:			
Address: *			Country:
Zip: *	City: *	State: *	
What is the reporting location?			
Did the accident occur on the employer's property? * ☐ No ☐ Yes			
If no, where did the accident occur? *		Address:	
Name: *			
Zip:	City:	State:	Country:
Was this the employee's regular department? ☐ No ☐ Yes		In what department did the accident occur?	
Was injury the result of a motor vehicle accident? ☐ No ☐ Yes		Was any equipment involved in the injury? ☐ No ☐ Yes If yes, what equipment?	
What was the employee doing just before the incident occurred?			
How did the accident occur? *			
What object or substance directly harmed the employee?			
Was safety equipment provided? ☐ No ☐ Yes		Was safety equipment used? ☐ No ☐ Yes	
If yes, what type?			
What was the injured body part(s)? *			
What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Upper ☐ Not applicable			
What is the nature of the injury (sprain, strain, etc.)? *			
What was the cause of injury? *			
Are you aware of a previous injury to this body part? * ☐ No ☐ Yes If yes, please explain: *			
Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ No ☐ Yes If yes, please explain: *			
Are there outside activities or medical conditions that would affect this injury? ☐ No ☐ Yes If yes, please explain: *			

List all **others** involved in the accident with contact information:

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

List all **witnesses** to the accident (or enter "none"):

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? * (Include a.m. or p.m.)

What time did the accident occur? * (Include a.m. or p.m.)

Who was notified of the accident?

When did the injured worker notify the employer? * (Date)

Did the claimant stop work? ☐ No ☐ Yes

What is the loss type?

☐ Incident only ☐ Indemnity ☐ Medical only ☐ Modified duty with no wage loss ☐ Modified duty with wage loss

What was the last date worked?

What time did the employee stop work? (Include a.m. or p.m.)

Has the employee returned to work? ☐ No ☐ Yes

Date of return to work?

Did/will the claimant return to full duty? ☐ No ☐ Yes

Do you have transitional/modified work available? ☐ No ☐ Yes

Number of hours per week?

Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? ☐ No ☐ Yes

Name of medical provider:

Medical facility/provider's address:

Zip:

City:

State:

Country:

Was employee treated in an emergency room? ☐ No ☐ Yes

Was employee hospitalized overnight as an in-patient?
☐ No ☐ Yes

What was the method of transportation? ☐ Helicopter ☐ Ambulance ☐ Personal vehicle ☐ Other

Do you require your employees to be drug tested? ☐ No ☐ Yes

If yes, when was the employee last tested?

Was an incident report completed? * ☐ No ☐ Yes

Do you have any reason to question this injury? * ☐ No ☐ Yes

Do you have any comments for the record?



Southmoreland School District
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 ensure that your medical treatment will be paid for by your employer or its 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.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Area of Specialty</u>
UPMC GoHealth Urgent Care (Multiple Locations)	6396 Route 819 South Mount Pleasant, PA 15666	724-547-3627	Urgent Care/Occupational Medicine
Independence Health Systems Occupational Medicine (Multiple Locations)	443 Frye Farm Road Upper Level Greensburg, PA 15601	724-765-1230	Occupational Medicine
Uniontown Medical Rehab (Multiple Locations)	675B Cherry Tree Lane Uniontown, PA 15401	724-430-5319	Physiatry
Independence Health System - Orthopedics (Multiple Locations)	854 Vanderbilt Road Suite 3 Connellsville, PA 15425	724-628-1455	Orthopedics
Allegheny Orthopaedic Associates - The Orthopaedic Institute (Multiple Locations)	118 Nature Park Road Greensburg, PA 15601	412-359-3895	Orthopedics
Independence Health Surgical Specialists (Multiple Locations)	508 South Church Street Mount Pleasant, PA 15666	724-547-8020	General Surgery
Associates in Neurology of Pittsburgh (Multiple Locations)	575 Coal Valley Road, Suite 104 South Hills Medical Building Clairton, PA 15025	412-466-3111	Neurology
AHN Neuroscience (Multiple Locations)	80 Matthew Drive Uniontown, PA 15401	412-267-6360	Neurosurgery
Glaucoma Cataract Consultants (Multiple Locations)	220 Bessemer Road, Suite 101 Mount Pleasant, PA 15666	724-547-5733	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
Mitchell ScriptAdvisor	Call Toll Free for Closest Location	1-866-846-9279	Pharmacy

Panel Date: 6/26/2025