



## Report of Injury

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



**Connellsville Area School District - All Locations**  
 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:WC100-2031129  
 Policy Effective Date:07/01/2025

**NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES**

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

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

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Independence Health WORKS - Greensburg	443 Frye Farm Rd Upper Level Greensburg, PA 15601	724-765-1230	Occupational Medicine
Tri-County Occupational Medicine	4000 Hempfield Plaza Blvd, Ste 991 Greensburg, PA 15601	724-205-6500	Occupational Medicine
*UPMC Washington Occupational Medicine - Waynesburg	220 Greene Plaza Waynesburg, PA 15370	724-223-3528	Occupational Medicine
*UPMC GoHealth Urgent Care LLC - Dunbar Twp/Morrell Ave (All Locations)	1440 Morrell Ave Connellsville, PA 15425	724-603-5022	Urgent Care
WVU Uniontown Hospital - Surgical Care	500 W Berkeley St, 3rd Fl Uniontown, PA 15401	724-430-5000	General Surgery
Independence Health System Surgical Specialists - Mt Pleasant	508 S Church St, first floor Excelsa Square at Frick Mount Pleasant, PA 15666	724-547-8020	General Surgery
*UPP Dept of Neurosurgery - McKeesport	500 Hospital Way, Ste 6 John Painter Building McKeesport, PA 15132	412-647-3685	Neurosurgery
*Tri-State Neurosurgical Associates - UPMC - Monroeville	600 Oxford Dr, Ste 210 Monroeville, PA 15146	877-635-5234	Neurosurgery
Conemaugh Neurosurgery - Somerset	1291 N Center Ave, Ste 100 Somerset Outpatient Center Somerset, PA 15501	814-534-5724	Neurosurgery
*UPP Dept of Non-Surgical Orthopaedics	8945 Route 30 UPMC Urgent Care North Huntingdon North Huntingdon, PA 15642	412-858-0385	Orthopedics
Independence Health System Orthopedics - Mt Pleasant	508 S Church St, Ste 200 Excelsa Square at Frick Mount Pleasant, PA 15666	724-547-1208	Orthopedics
Penn Highlands Orthopedics & Sports Medicine - Uniontown	150 Wayland Smith Dr Uniontown, PA 15401	724-437-8200	Orthopedics
Independence Health System Orthopedics - Greensburg/680 Pellis Rd	680 Pellis Rd Greensburg, PA 15601	724-689-1970	Orthopedics
Laurel Ridge Eyecare	139 W Fayette St Uniontown, PA 15401	724-437-2222	Ophthalmology

In 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.



**Connellsville Area School District - All Locations**  
 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: WC100-2031129  
 Policy Effective Date: 07/01/2025

**NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES**

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

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

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Bigley Eyecare Associates	11 N Chestnut St Scottdale, PA 15683	724-887-5820	Ophthalmology
Martinelli Eye & Laser Center - Uniontown	107 Matthew Dr Uniontown, PA 15401	724-437-6000	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

In 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 INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

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

Department of Labor & Industry  
Bureau of Workers' Compensation  
651 Boas Street 8th Fl  
Harrisburg, Pennsylvania 17121-0750  
Telephone No. within Pennsylvania: 1-800-482-2383  
Telephone No. outside of this Commonwealth: 717-772-4447  
TTY: 1-800-362-4228 (for hearing and speech impaired only)  
[www.state.pa.us](http://www.state.pa.us), PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, \_\_\_\_\_, employee of \_\_\_\_\_,  
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: \_\_\_\_\_

**Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.**

Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230





**WORKERS' COMPENSATION AUTHORIZATION  
FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Employee's Full Name	Claim Number
Address	Date of Birth
City, State Zip Code	Telephone Number
Employer	

I hereby authorize the release of my protected health information (PHI) or other information relevant or potentially related to the injury or condition indicated below to WorkPartners, on behalf of UPMC Benefit Management Services, Inc. or UPMC Health Benefits, Inc., as applicable, its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.

Description of Injury or Condition: \_\_\_\_\_

Date of Injury or Condition: \_\_\_\_\_

Such disclosure may contain PHI or other information related to my Workers' Compensation medical condition or other condition(s) noted above, including, but not limited to, medical records, patient files, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings, provided all requests for this information are in writing.

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation, provided that such duration shall not exceed two years from the date of the signature on the following page.

I understand that WorkPartners may be required to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including but not limited to Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I certify that all of the information that I have provided is, to the best of my knowledge, true, correct, and complete.



**IMPORTANT INFORMATION ABOUT YOUR RIGHTS**

- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing (see #2 on the next page), but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners.
- I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please return this completed and signed form by fax to 412-454-8717 or by mail to WorkPartners, PO Box 2971 Pittsburgh, PA 15230.

1. Type of records to be released (check all that apply):

- Inpatient
- Outpatient
- Diagnostic testing
- Other: \_\_\_\_\_
- Emergency department
- Physician/Office
- Physical therapy

Unless you check the box(es) immediately below, no information about alcohol/substance abuse, HIV/AIDS or behavioral health will be disclosed:

- YES, disclose information related to alcohol/substance abuse
- YES, disclose Information Related To HIV/AIDS
- YES, disclose Behavioral Health Information

2. I may revoke this authorization by notifying:

UPMC Insurance Services Division  
Attn: Chief Privacy Officer  
600 Grant Street  
Pittsburgh, PA 15219  
HealthPlanCPO@upmc.edu

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

Signature of Employee	Date of Employee's Signature	Employee's Date of Birth or Claim Number
-----------------------	------------------------------	--

OR, if applicable –

Signature of Parent, Legal Guardian or Authorized Representative	Date of Parent, Legal Guardian or Authorized Representative's Signature	Description of Authority to Act for the Employee (i.e., Parent, Legal Guardian or Authorized Representative)
--	---	--

*A copy of this completed, signed and dated form must be given to the member or other signator.*

<b>Official Use Only</b>		
_____	_____	_____
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: \_\_\_\_\_



## 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

### Drug Emporium

A & P  
Acme Pharmacy  
Albertson's  
Albertson's/Acme  
Albertson's/Osco  
Albertson's/Sav-On  
Amerisource Bergen  
Anchor Pharmacies  
Arrow  
Aurora  
Bartell Drugs  
Bigg's  
Bi-Lo  
Bi-Mart  
BJ's Wholesale Club  
Brooks  
Brookshire Brothers  
Brookshire Grocery  
Bruno  
Carrs  
Cash Wise  
Coborn's  
Costco  
Cub  
CVS  
D&W  
Dahl's  
Dierbergs  
Discount Drugmart  
Doc's Drugs  
Dominicks

Drug Fair  
Drug Town  
Drug World  
Eckerd  
Econofoods  
EPIC Pharmacy  
Network  
FamilyMeds  
Farm Fresh  
Farmer Jack  
Food City  
Food Lion  
Fred's  
Gemmel  
Giant  
Giant Eagle  
Giant Foods  
Hannaford  
Harris Teeter  
H-E-B  
Hi-School Pharmacy  
Hy-Vee  
Jewel/Osco  
Kash n Karry  
Keltsch  
Kerr  
Kmart  
Knight Drugs  
Kroger  
LeaderNet (PSAO)

Longs Drug Store  
Major Value  
Marsh Drugs  
Medic Discount  
Medicap  
Medistat  
Meijer  
Minyard  
NCS HealthCare  
Neighborcare  
Network  
Pharmaceuticals  
Northeast Pharmacy  
Services  
Osco  
P & C Food Markets  
Pamida  
Park Nicollet  
Pathmark  
Pavilions  
Price Chopper  
Publix  
Quality Markets  
Raley's  
Randalls  
Rite Aid  
Rosauers  
Rx Express  
RXD  
Safeway  
Sam's Club

Sav-On  
Save Mart  
Schnucks  
Scolari's  
Sedano  
Shaw's  
Shop 'N Save  
Shopko  
ShopRite  
Snyder  
Stop & Shop  
Sun Mart  
Super Fresh  
Super Rx  
Target  
Texas Oncology Svcs  
The Pharm  
Thrifty White  
Times  
Tom Thumb  
Tops  
Ukrop's  
United Drugs  
United Supermarkets  
Vons  
Waldbaums  
Walgreens  
Wal-Mart  
Wegmans  
Weis  
Winn Dixie