RICHLAND TOWNSHIP
EMPLOYEE INJURY REPORTING PACKET

WHAT TO DO WHEN YOU ARE INJURED AT WORK:

- ***COMPLETE THE FOLLOWING FORMS:***
    1. Read, sign and date the **Medical Treatment for Your Work Injury or Occupational Illness** and **WC Information Form** acknowledging you were advised of your rights under the PA WC Act.
    2. Complete the **Employee Statement of Injury or Illness**, sign and date the form.
    3. Complete, sign and date the **Authorization to Release Medical Records** allowing for more-timely request of medical records to process your claim.

- ***TAKE THE FOLLOWING FORMS WITH YOU AFTER THE PAPERWORK ABOVE HAS BEEN COMPLETED:***
    1. The **Physician Panel** listed below.
    2. Copies of the completed forms above that will be provided to you.
    3. **Occupational Injury Temporary Prescription ID Card** provided by the carrier so that you can obtain prescriptions from any participating pharmacy.

PHYSICIAN PANEL

PROVIDER	ADDRESS	PHONE NUMBER	SPECIALITY
Corporate Care Services	1450 Scalp Avenue, Suite 106 Johnstown, PA 15904	814-266-8466	OCCUPATIONAL MEDICINE
Medexpress Urgent Care	1221 Scalp Avenue Johnstown, PA 15904	814-266-1138	URGENT CARE CLINIC
iCare Medical (Multiple Locations)	411 Theatre Drive Johnstown, PA 15904	814-266-3934	URGENT CARE CLINIC
Mckolosky, Dennis, DC	401 Theatre Drive Johnstown, PA 15904	814-269-3116	CHIROPRACTOR
Pinnacle Chiropractic Spine & Sports Center	335 Nees Avenue Johnstown, PA 15904	814-266-3226	CHIROPRACTOR
Kulback Eyecare and Chiropractic	1110 Scalp Avenue Johnstown, PA 15904	814-266-6888	CHIROPRACTOR
Ross Chiropractic	2831 Bedford Street Johnstown, PA 15904	814-266-3911	CHIROPRACTOR
Center for Orthopedic & Sports Medicine (COSM)	374 Theatre Dr, 2nd Floor Johnstown, PA 15901	814-535-6521	ORTHOPEDIC
Western PA Ortho & Sports Medicine	2 Celeste Drive Johnstown, PA 15905	814-255-6781	ORTHOPEDIC
CSSMCW Orthopedic Walk-In Clinic	374 Theatre Dr., Ste 201 Johnstown, PA 15904	814-467-3628	ORTHOPEDIC
Conemaugh Physician Group – General Surgery	415 Napoleon Place Johnstown, PA 15905	814-539-8725	GENERAL SURGERY
Conemaugh Physician Group – Neurosurgery	1111 Franklin Street, Suite 130 Johnstown, PA 15905	814-534-5724	NEUROSURGERY
MedRisk	Requires adjuster approval	800-225-9675	PHYSICAL THERAPY
Ophthalmic Associates	120 Main Street Johnstown, PA 15901	814-536-5343	OPHTHALMOLOGY
Absolute Solutions	For the nearest location, please call the toll free number.	800-321-5040	MRIs, CTs and EMGs
myMatrixx	Call for Nearest Retail Network Location	800-945-5951	PHARMACY

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 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 __each department__ for you to view. Also, you may get a copy of this list from _____the Admin office_____.

If you are injured at work or suffer an occupational illness, you have certain legal **RIGHTS** and **DUTIES** under Section 306(f.l)(l)(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 **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 6 providers are shown on the next page. 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: _____

Pennsylvania Workers' Compensation Information

In Pennsylvania, 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 when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for 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 at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

Telephone number within Pennsylvania: 800-482-2383
Telephone number outside of this Commonwealth: 717-772-4447

TTY- 800-362-4228 (for hearing and speech impaired only)

www.state.pa.us, PA Keyword: workers comp.

This notice was presented to me at (check one):

___ ***Time of hire*** ___✓___ ***When I was injured*** ____ ***Other***

Employee Signature: _____***Date***: _____

Employer Signature: _____***Date***: _____

Employee Statement of Injury or Illness

EMPLOYEE INFORMATION
(To be completed by the Employee)

Name:
Last First Middle Initial

Address:
Street

City State Zip Code County

Phone Number:	Sex: ☐ M ☐ F	# of Dependents:

Marital Status: ☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Other

Date of Birth:	S.S. #:	Date of Hire:

Employers' Name	Location Where You are Employed:
Occupation/Job Title:	Department:

Supervisor's Name:

ACCIDENT INFORMATION

Date of Accident:	Time of accident: ☐ AM ☐ PM
Time Employee Began Work: ☐ AM ☐ PM	Worked Until End of Normal Shift: ☐ Yes ☐ No
Date Accident Reported to Employer:	Name of Person Accident Reported to:
Did Accident Occur on Employer's Premises? ☐ Yes ☐ No	Location of Accident:

Description of Accident (describe how the accident occurred, be specific):

Did you seek medical care? ☐ Yes ☐ No

If Yes, where?

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No	Were Safeguards or Safety Equipment Used? ☐ Yes ☐ No

ACCIDENT INFORMATION

DESCRIBE YOUR INJURY:

_____
_____
_____
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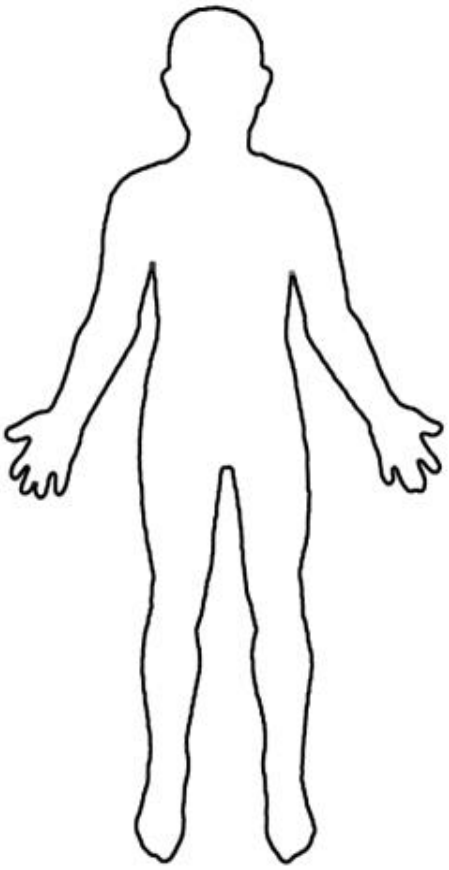
_____
_____

BODY PART(S) INJURED:

- ☐ Arm
- ☐ Elbow
- ☐ Shoulder
- ☐ Hand
- ☐ Wrist
- ☐ Finger
- ☐ Hip
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Toe
- ☐ Back
- ☐ Neck
- ☐ Head
- ☐ Face
- ☐ Eye
- ☐ Stomach
- ☐ Groin
- ☐ Other_____

Left Right



Put an (x) on Injured Body Part

Be sure to include right or left side in your description of injury.

Name and Phone Number of Any Witnesses:

SIGNATURE AND CONFIRMATION

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.

_____ _____

Employee Signature: **Date:**

Authorization to Release Medical Records

Injured Employee: _____

Employer: _____

Authorization to Release Medical Information

The undersigned authorizes and directs any physician, surgeon, therapist, or hospital that has attended, examined, or treated me to furnish to my employer, their workers' compensation insurance carrier, as well as the agent of record, upon their request, any and all information and records, or copies of records relating to attendance, examination or treatment rendered me in connection with my injury or illness, with the further privilege of personal examination of such records if necessary.

A photocopy of this authorization shall serve in its stead.

Name: _____

Address: _____

City, State and Zip: _____

Social Security Number: _____

Date of Birth: _____

_____
Employee's Name (Please Print)

_____ _____
Employee's Signature Date

Occupational Injury Temporary Prescription ID Card

count on EMC INSURANCE | myMatrixx An Express Scripts Company

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 work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 800-945-5951.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800-945-5951.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 15-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 myMatrixx 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

myMatrixx, an Express Scripts Company

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 #: W9BA
_____

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.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

CRP1806_0245 EME46657 OT48016Y

Occupational Injury Temporary Prescription ID Card

Participating Retail Network Pharmacies

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 Emporium
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 Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie