Boyertown Area School District

Human Resources

Workers' Compensation Employee Injury Packet

In the event of a medical emergency…seek medical attention immediately

Employee Responsibilities if Injured:

☐ **Report** injuries to your supervisor or building principal to receive this packet of instructions**.**

☐ **Select** a treating physician from the approved provider panel in this packet if treatment is needed.

☐ **Sign and Return:**

"Employee Incident Report" (Pages 2 & 3)

"Rights and Duties Form" (Page 6)

"Medical Record Release Authorization" (Page 7)

Return to: ***Kristin Hile, Human Resources – Education Center***

Keep the remainder of the packet for future reference.

Read all information in the packet carefully. Please call Kristin Hile at 610-369-7606 for any questions or concerns.

BOYERTOWN AREA SCHOOL DISTRICT
EMPLOYEE INCIDENT REPORT

SECTION ONE: EMPLOYEE INFORMATION

1. Name: _____
2. Street Address: _____
3. City: _____ State: _____ Zip: _____ County: _____
4. SSN: _____ DOB: _____
5. Job Tile: _____
6. Phone: _____ Alternative Phone: _____
7. Email Address: _____

SECTION TWO: INCIDENT INFORMATION

1. Date of Injury: _____
2. Time of Injury: _____
3. Location of Injury
    a. **Choices:** Senior High, Ed Center, Support Services, Middle School East, Middle School West, Washington, Boyertown, Colebrookdale, Earl, Gilbertsville, New Hanover, Washington

    _____

    b. **Examples:** classroom, hallway, playground, parking lot, etc.

    _____
4. Type of Injury (concussion, contusion, fracture, sprain, burn, etc): _____
5. Accident Cause: _____
   (Fall From, Strain/Overexertion, Slip/Fall, Caught In-Between, Struck Against or By, Heat or Cold, Cut/Puncture/Scrape, Motor Vehicle Accident, etc)
6. Body Part(s) Injured: _____
7. Description of Accident: _____

    _____

    _____

    _____
8. Witnesses: _____
9. Incident Reported to: _____
10. Date Supervisor or Principal Notified: _____
11. Name of Supervisor or Principal: _____

SECTION THREE: MEDICAL TREATMENT

☐ No treatment elected (please sign page 3)

☐ Medical treatment elected (please complete and sign section 3)

SECTION FOUR: INFORMATION IF SEEKING MEDICAL TREATMENT

NOTE: Employees must choose one of the medical providers listed on the provider panel on Page 5 when seeking treatment for a Workers' Compensation injury.

List the chosen medical provider below.

1. Physician/Health Care Provider Name and Address:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: _____ Fax: _____

2. Hospital Name and Address:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: _____ Fax: _____

3. Date of this report: _____

4. Employee's Signature_____

Boyertown Area School District – Boyertown, PA

Your Workers' Compensation Insurance
Carrier is: CM Regent Insurance
300 Sterling Pkwy, Suite 100 Mechanicsburg, PA 17050

Phone: 1-717-590-8008

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR WORK INJURY.

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 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.
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.

FOR ASSISTANCE IN SCHEDULING APPOINTMENTS, PLEASE CALL PREMIER COMP TOLL FREE 24 HOURS/7 DAYS A WEEK AT 1-888-594-4001

Name	Address	Phone	Area of Specialty
Tower Health Urgent Care (Multiple Locations)	1139 West Ben Franklin Highway Douglassville, PA 19518 Location #: 610-385-4444	1-888-594-4001	Urgent Care/Occupational Medicine
Occupational Health Pottstown Hospital-Tower Health	81 Robinson Street Pottstown, PA 19464 Location #: 610-326-2300	1-888-594-4001	Occupational Medicine
Robert W. Mauthe, MD	4676 Route 309 Center Valley, PA 18034 Location #: 610-791-7690	1-888-594-4001	Physiatry
Rothman Orthopaedic Institute (Multiple Locations)	400 Enterprise Drive, 2nd Floor Limerick, PA 19468 Location #: 267-339-3776	1-888-594-4001	Orthopedics
Premier Orthopedics (Multiple Locations)	1561 Medical Drive Pottstown, PA 19464 Location #: 610-792-9292	1-888-594-4001	Orthopedics
Philadelphia Hand to Shoulder Center (Multiple Locations)	Phoenixville Medicine at Limerick 420 West Linfield-Trappe Road, Suite 1100 Limerick, PA 19468 Location #: 800-385-7472	1-888-594-4001	Orthopedics - Hand/Wrist/Elbow
Pottstown Surgical Associates	1329 East High Street, Suite 1 Pottstown, PA 19464 Location #: 610-326-8400	1-888-594-4001	General Surgery
Einstein Neurosurgery Associates	100 Market Street, Providence Tower Center Collegeville, PA 19426 Location #: 215-456-6127	1-888-594-4001	Neurosurgery
Parks Chiropractic PC	137 Montgomery Avenue, Suite 103 Boyertown, PA 19512 Location #: 610-367-7850	1-888-594-4001	Chiropractic

CM REGENT™ INSURANCE COMPANY

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Corvel	For Prescriptions, Please Call	1-800-563-8438	Pharmacy
S1 Medical	Call Toll Free for Closest Location	1-888-945-5055	DME and Home Health

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RIGHTS AND DUTIES FORM

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.l)(l)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.l)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.l)(l)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.l)(l)(i) and that I understand them to the extent that they are explained above.

Print Name	Employee Signature	Date

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits with respect to this claim, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim and the payment of benefits or the administration of the insurance program under which the claim has been made. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to CM Regent Insurance Company, PO Box 813, New Cumberland, PA 17070, otherwise this authorization will continue to be valid. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization unless you indicate to the contrary in writing.

Authorization to Release Medical Information

I hereby authorization any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to CM Regent Insurance Company, and their subsidiaries, affiliates, representatives, and agents (collectively, CM Regent Insurance Company), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems.

I also authorize the Social Security Administration to release to CM Regent Insurance Company information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize CM Regent Insurance Company to release any such medical information to its insurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that CM Regent Insurance Company considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand the information released to CM Regent Insurance Company as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for three years after the claim has been closed by CM Regent Insurance Company. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____Date_____

Print Name _____