PENN CAMBRIA SCHOOL DISTRICT

WORKERS COMPENSATION PACKET

COVERAGE PROVIDED BY EASTERN ALLIANCE INSURANCE COMPANY

EFFECTIVE JULY 1, 2014

- ☐ Accident Investigation Form – shall be completed by Building Principal, or Supervisor with copy provided to Building Principal.
- ☐ Claim Reporting Worksheet
- ☐ Employee Acknowledgement of Rights & Duties
- ☐ Physician Panel (revised April 2021)

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Created 08/18/2014
Modified 11/07/2016
Modified 03/31/2017
Modified 03/14/2022

Penn Cambria School District
Accident Investigation Form

NOTE: This form shall be completed by Building Principal or Supervisor, with copy provided to Building Principal.

Employee Name _____ Building _____

Date and time of injury ___/_____/_____
_____:_____ AM or PM (circle one)

Normal starting time:
_____:_____ AM or PM (circle one)

Where did the accident/injury occur? (e.g., room #, room identifier, parking lot, etc.)

_____

_____

_____

Describe the injury sustained: _____

_____

_____

_____

Identify any materials, item or equipment being used at the time of the accident/injury.

_____

Were all safety devices in use at the time of the accident/injury? _____ YES _____ NO
Explain:

_____

_____

_____

How did the accident/injury occur? _____

_____

_____

_____

How can this accident/injury be prevented from happening again?

_____

_____

_____

Provide names and contact information of all witnesses to the accident/injury.

_____

_____

_____

_____ _____/_____/_____

Form completed by (must be Building Principal or Supervisor) Today's Date

Highlighted Sections to be completed by Employee and Building Principal and/or Supervisor.

EASTERN ALLIANCE INSURANCE GROUP CLAIM REPORTING WORKSHEET

24/7 TELECLAIM: 1-800-336-3658 / ONLINE: WWW.EAINS.COM

INSURED INFORMATION

Name and Title of Caller: _____ Phone Number: 814-886-8121

Insured Name: PENN CAMBRIA SCHOOL DISTRICT Policy #: 0000085518

Insured Address: 201 6TH STREET, CRESSON, PA 16630-1363

County: CAMBRIA

Contact Person for Claims: WORKERS COMP COORDINATOR Contact Phone Number: 814-886-8121 x1008

EMPLOYEE INFORMATION

Name: _____ SS#: _____

Home Address: _____ Phone: _____

County: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ # of Dependents: _____

Date of Hire: _____ Hire State: _____ Job Title: _____

Supervisor's Name & Phone Number: _____

Did Employee Received Pay While Off Work Due to Injury?: _____ Employment Status: FT_____ PT_____ Temp_____

ACCIDENT INFORMATION

Date and Time of Accident: _____ Time Shift Begins: _____

Did Accident Occur on Employer's Premises?: _____ Date Reported to Employer: _____

Accident Physical Address: _____ County: _____

Accident Description (Include nature of injury, body part injured, & cause of accident):

_____

_____

_____

Did Accident Result in a Fatality?: _____ Date of Death: _____

Was Time Lost as a Result of the Injury?: _____ Last Date Employee Worked: _____

First Full Day of Work Missed Due to Accident: _____

Has Employee Returned to Work?: _____ Date Returned to Work: _____

Were Safeguards or Safety Equipment Provided?: _____

ACCIDENT INVESTIGATION

Witness Name: _____

Address: _____ Phone: _____

TREATMENT INFORMATION

Did Employee Seek Any Medical Treatment?:

Name of Medical Provider: _____ Is this a Panel Provider?: _____

Address: _____ Phone: _____

Was Employee Hospitalized?: _____ Admit Date: _____

Appendix B

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Workers' Compensation is designed to provide wage loss benefits and payment for reasonable medical care for one who is injured on the job.

Remember: It is important to tell your employer about your injury immediately.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you must select. You must obtain treatment from one or more of these providers for ninety (90) days from the date of your first visit.

If you have a medical emergency, you may go to the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you seek treatment from a non-panel provider within the first ninety (90) days following your first visit, your employer will not have to pay for those services.

In the event invasive surgery is prescribed by a physician or other health care provider on your employer's panel, you are entitled to a second opinion from any other health care provider of your choice. If the opinion differs from the one provided by the panel provider, you may choose which course of treatment to follow. However, the second opinion must state a specific course of treatment. If you choose the treatment offered by the second opinion you must receive that treatment from a panel provider for a period of ninety (90) days from the date of the visit to the provider of the second opinion.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of services rendered if such services are determined to have been unreasonable or unnecessary. The non-panel provider must provide an initial report to the employer, within ten (10) days of the first treatment and every thirty (30) days thereafter, as long as the treatment continues.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

☐ ***At Time of Hire*** ☐ ***After an Injury***

Employee Signature_____ Date_____

Witness Signature_____ Date_____

Penn Cambria School District - Cresson (16630)
(4/23/2021)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

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 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 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.

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 CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-855-572-3926 FOR ASSISTANCE IN SCHEDULING PHYSICAL/OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITIATION OR SEND THE REFERRAL FORM TO easternreferrals@medrisknet.com

Name	Address	Scheduling	Area of Specialty
MedExpress Urgent Care	300 E Plank Rd Altoona, PA 16602	814-946-3801	Occupational Medicine
MedExpress Urgent Care	1221 Scalp Ave Johnstown, PA 15904	814-266-1138	Occupational Medicine
University Orthopedics Center	3000 Fairway Drive Altoona, PA 16602	814-942-1166	Orthopedics
Total Care Orthopedics	321 Main St Suite 3C Johnstown, PA 15901	814-535-6521	Orthopedics
UPMC Altoona Elite Orthopaedics	800 S Logan Blvd Ste 2200 Hollidaysburg, PA 16648	814-889-3600	Orthopedics
Allegheny Brain and Spine Surgeons	501 Howard Ave Ste E1 Altoona, PA 16601	814-946-9150	Neurosurgery
Laurel Eye Clinic	176 Vision Dr Duncansville, PA 16635	814-949-8808	Ophthalmology
Ophthalmic Associates	120 Main St Johnstown, PA 15901	814-536-5343	Ophthalmology
MedRisk PT/OT Network	Call Toll Free for Scheduling	1-855-572-3926	Physical and Occupational Therapy
MedRisk Chiro Network	Call Toll Free for Scheduling	1-855-572-3926	Chiropractic Care
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI
Carlisle Medical, Inc.	Call Toll Free for Closest Location	1-800-553-1783	DME
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	DME/Pharmacy
Homelink	Call Toll Free for Closest Location	1-800-571-2943	DME/Supplies

Penn Cambria School District - Cresson (16630)
(4/23/2021)
NOTA A EMPLEADOS EN CASO DE LESIONES DE TRABAJO

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717)396-7095
(855)533-3444

1. Si sufre una lesión en el trabajo o su empleador o su compañía de seguros le deben pagar por servicios y suministros razonables quirúrgicos y médicos, aparatos y prótesis ortopédicos, inclusive la instruction en su uso.

2. Para asegurar que su tratamiento médicos sea pagado por su empleador o la compañía de seguros, ústed debe seleccionar uno de los proveedores de la lista abajo de esta página.

3. Debe de seguir consulatando a uno de los médicos de la lista que se encuentra abajo do este página si necesita tratamiento, por noventa (90) días de la fecha de su primera visita.

4. Si una de las personas de este lista le se refiere a otro especialista licenciado, su empleador o su asegurador pagarán las facturas para estos servicios.

5. Despues de los primeros noventa (90) días, si usted todavia necesita tratamiento y su empleador le ha proporcionado una lista como la que se encuentra abajo, ústed puede escoger ir a otro proveedor de la asistencia medica para el tratamiento. Debe notificar a su empleador de este acción dentro de cinco dias de su visita incial.

6. Si su médico de la lista le receta cirugía invasiva, ústed puede pedir una segunda opinión de cualquier otro médico. Si la opinión del otro médico difiere de la del médico de la lista ústed puede decidir que tipo de tratamiento desea recibir. Sin embargo, la segunda opinion deberá contener un plan de tratamiento especifico y detailedo. Si ústed elige la segunda opinión, los procedimientos de la segunda opinión deberan ser realizados por uno de los médicos de la lista por los primeros noventa (90) días. Por lo tanto, en este situación, el trabajador puede estar obligado a tratar con un proveedor designado por el empleador durante un máximo de 180 días

7. Si ústed se enfrenta a una emergencia médica, puede asegurar ayuda de un hospital, médicos, o de un proveedor de asistencia médica de su preferencia para su lesión de trabajo. Sin embargo, cuando la emergencia sea resuelta, ústed debe buscar tratamiento de un proveedor de la lista que se encuentra on este página.

POR FAVOR LLAMADA EASTERN ALLIANCE'S QUE PLANIFICA SERVICIOS TOCA LIBERTA EN 1-855-572-3926 PARA LA AYUDA A PLANIFICAR CON FISICO/REHABILITACION DE TERAPIA OCUPACIONAL O QUIROPRACTICA O ENVIAR LA REFERENCIA DE A easternreferrals@medrisknet.com

Nombre de Clínica	Dirección	Consultas	Area De Especialidad
MedExpress Urgent Care	300 E Plank Rd Altoona, PA 16602	814-946-3801	Occupational Medicine
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Ophthalmic Associates	120 Main St Johnstown, PA 15901	814-536-5343	Ophthalmology
MedRisk PT/OT Network	El Peaje de la llamada Liberta Par Planificación	1-855-572-3926	Physical and Occupational Therapy
MedRisk Chiro Network	El Peaje de la llamada Liberta Par Planificación	1-855-572-3926	Chiropractic Care
One Call Care Management	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-872-2875	MRI
Carlisle Medical, Inc.	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-553-1783	DME
KeyScripts	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-866-446-2848	Pharmacy
Homelink	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-571-2943	DME/Supplies