WorkPartners

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 ❑ a.m. ❑ p.m.
Social Security Number	Date of Birth		Date of Hire
Occupation			
❑ Full-time ❑ Part-time	If Part-Time, Days Worked ❑ Mon ❑ Tues ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun		Name of Other Employer
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time ❑ a.m. ❑ p.m.	Date Reported	Time ❑ a.m. ❑ p.m.
Did incident occur on employer's premises? ❑ Yes ❑ No Where:			
Performing regular job at the time of incident? ❑ Yes ❑ No			
Losing time? ❑ Yes ❑ 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

UPMCHP WC COMM IMJURY RPRT 17WP2017 (MJA) 10/9/17 PDF

WorkPartners

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.

WorkPartners

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.

Official Use Only		
Received	**Processed By**	**Log #**

WorkPartners

Provider Information: please use additional sheets of paper as needed

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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: _____

WorkPartners

P.O. Box 2971 | Pittsburgh, PA 15230 | www.workpartners.com

Claim Reporting Methods

Telephonically: 1-800-633-1197

Fax: 412-454-0999

Email: CommercialWCClaims@UPMC.edu

Online: https://wc.workpartners.com/upmc/

Address
WorkPartners
PO Box 2971
Pittsburgh, PA 15230

Phone Number:
800-633-1197

Fax:
412-454-8717

Forms utilized at time of injury

- **Report of Injury** – This form captures the data needed when reporting a claim. If not reporting a claim online, the form can be sent via email or fax. This should be completed by the supervisor or manager.

- **Panel with Employee's Rights and Duties** – The Panel and Employee's Rights and Duties are to be given together to an employee anytime a change is made to the Panel, at time of hire and also at the time of an injury. By signing the Employee's Rights and Duties, the employee acknowledges he or she has been made aware of the Panel and must treat with a provider on the Panel for the first 90 days.

- **Medical Authorization** – This is to be given to the injured employee at the time of the injury.

- **First Fill Form** – This is to be given to the injured employee at the time of injury. They can present it to the pharmacy at the time they are having their first prescription filled. The pharmacy will then direct bill us for the prescription. The injured employee will then receive a prescription card in the mail to use for future prescriptions.

Workers' Compensation Temporary Prescription ID Card

WorkPartners

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 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.

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.

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

Employee Information

First _____ M _____ Last _____

Street Address or PO Box _____

City _____ State _____ ZIP _____

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

WorkPartners

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

workpartners

Carlynton School District - Carnegie (15106+)
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:WC100-2030815
Policy Effective Date:07/01/2020

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.

Name	Address	Scheduling	Area of Specialty
*Concentra Medical Center - Robinson	4390 Campbells Run Rd Pittsburgh, PA 15205	412-429-9675	Occupational Medicine
*Concentra Medical Center - West End	1600 W Carson St, Ste 200 Pittsburgh, PA 15219	412-391-1137	Occupational Medicine
MedExpress Urgent Care - Scott Township	1984 Greentree Rd Pittsburgh, PA 15220	412-343-3627	Urgent Care
*UPP Dept of General Surgery - UPMC Mercy	1400 Locust St, Ste 3121 UPMC Mercy Hospital Pittsburgh, PA 15219	412-281-2255	General Surgery
*UPP Dept of Neurosurgery - Pittsburgh	1350 Locust St, Ste 300 UPMC Mercy Professional Building Pittsburgh, PA 15219	412-471-4772	Neurosurgery
*Orthopaedic Specialists - UPMC - South Side	2100 Jane St, Ste 7100 Pittsburgh, PA 15203	877-471-0935	Orthopedics
*UPP Dept of Orthopaedic Surgery - Oakland	3471 Fifth Ave, Ste 1010 Kaufmann Medical Building Pittsburgh, PA 15213	412-858-0385	Orthopedics
*UPMC Eye Center - Oakland	203 Lothrop St, Ste 718 Eye & Ear Institute Pittsburgh, PA 15213	412-647-2200	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

Panel updated: 6/12/2020

WorkPartners

NOTICE TO EMPLOYEES
Health Care Provider Panel and Procedures

IN CASE OF A WORK INJURY OR ILLNESS:

1. You must immediately report the injury or illness to your supervisor.
2. To report the injury/illness, the employee's supervisor/manager is responsible for calling WorkPartners Claims Management Services at 1-800-633-1197. The employee's supervisor/manager should report all injuries/illnesses to WorkPartners within 48 hours. All correspondence and bills must be directed to:

WORKPARTNERS
Claims Management Services
PO Box 2971
Pittsburgh, PA 15230
Fax: (412) 454-8717

3. To ensure that bills associated with medical treatment will be paid by WorkPartners, you must select from one of the licensed physicians or health care providers listed below.

If there are any questions concerning this notice, please call 1-800-633-1197.

REQUIRED NOTICE OF EMPLOYEE RIGHTS AND DUTIES

(1) The employee has 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.

(2) The employee has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.

(3) The employee has the right during this 90-day period to switch from one health care provider on the list to another provider on the list and to have all the treatment paid for by the employer.

(4) The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.

(5) The employee has the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.

(6) The employee has the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but these services shall be at the employee's expense for the applicable 90 days.

(7) The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer if it is reasonable and necessary.

(8) The employee has the duty to notify the employer of treatment by a nondesignated provider within five days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a nondesignated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless that treatment is found to be unreasonable by a utilization review organization (URO), under Subchapter C (relating to medical treatment review).

(9) The employee has the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

WorkPartners

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 in a prominent and easily accessible place the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment. 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:

Bureau of Workers' Compensation
1171 South Cameron St., Room 103
Harrisburg, PA 17104-2501
Within PA: 1-800-482-2383
Outside PA: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
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 _____,
(employee)

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.

EMPLOYEE'S ACKNOWLEDGMENT FORM UNDER
SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six designated health care providers, no more than two of whom are coordinated care organizations and no fewer than three of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for 90 days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this 90-day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five days of my first visit to each and every nondesignated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature _____ Date _____

Employee's Name (Print) _____ Employee Number _____

Employer _____ Department _____

Witness' Signature _____ 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.

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Pittsburgh, PA 15219
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