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 building leadership immediate after incident occurs

☐ **Injury Packets** can be found on the Boyertown Area School District website under "staff resources, human resource forms, Workers' compensation injury packet.

☐ **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 5)

"Medical Record Release Authorization" (Page 6)

Return to:

Cindi Bartholomew
Human Resources – Education Center
Email: cbartholomew@boyertownasd.org
Phone: 610-473-3507 or extension 3507

Keep the remainder of the packet for future reference.

Read all information in the packet carefully. Please call Cindi with any questions or concerns.

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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: OCCURRENCE INFORMATION

1. Date of Injury: _____ Start Time of Employee Shift _____
2. Time of Injury: _____ End Time of Employee Shift _____
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: _____

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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 Approved Provider Panel

The following procedures must be followed in case of work related injury or illness:

A. **Immediately report the injury to your supervisor.**

Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. Supervisors must promptly report injuries to the appropriate personnel office.

B. **Obtain medical care from a provider listed below.**

Tower Health Urgent Care
(Multiple Locations)
Urgent Care/Occupational Medicine
1139 W Ben Franklin Hwy
Douglassville, PA 19518
610-385-4444

Occupational Health- Pottstown Memorial Medical Center
Occupational Medicine
81 Robinson Street
Pottstown, PA 19464
610-326-2300

Rothman Orthopaedic Institute
(Multiple Locations)
Orthopedics
400 Enterprise Drive, 2nd Floor
Limerick, PA 19468
267-339-3776

Premier Orthopaedics
(Multiple Locations)
Orthopedics
1561 Medical Dr
Pottstown, PA 19464
610-792-9292

Philadelphia Hand to Shoulder Center
(Multiple Locations)
Orthopedics: Hand/Wrist/Elbow
1561 Medical Drive
Pottstown, PA 19464
610-792-9292

Pottstown Surgical Associates
Surgery: General
1329 E High St Ste 1
Pottstown, PA 19464
610-326-8400

Einstein Neurosurgery Associates
Surgery: Neurosurgery
100 Market St Ste 300
Collegeville, PA 19426
215-456-6127

Parks Chiropractic
Chiropractic
137 Montgomery Ave
Boyertown, PA 19512
610-367-7850

Complete Family Eyecare
Ophthalmology
1806 Swamp Pike Ste. 400
Gilbertsville, PA 19525
610-323-4445

Sterling Optical
Ophthalmology
1100 Heritage Drive, Ste. B
Pottstown, PAS 19464
610-326-2754

Optum
Available at any major pharmacy
PHARMACY
800-393-1398

Heads Up
For the nearest location, please call the toll free number.
DENTIST
855-443-9872

One Call Medical Diagnostics
Requires adjuster approval
DIAGNOSTICS
866-672-3064

One Call Care
Requires adjuster approval
PHYSICAL THERAPY
866-672-3064

Hospital
For Emergency Services, please go to the nearest hospital.
HOSPITAL
(FOR EMERGENCY SERVICES ONLY)

C. **Medical Emergency:**

If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. **If you choose to treat with an out of state provider, you may be subject to balance billing.**

E. **For medical treatment to be paid by your employer:**

1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

***For medical groups, all providers are eligible to render medical services.**

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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 _____