EAST COAST RISK MANAGEMENT
40 Lincoln Way Suite 201
North Huntingdon, PA 15642
P–724-864-8745 / F–724-864-9265

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

I hereby authorize and direct you to permit, East Coast Risk Management, to inspect, examine, make or obtain copies of all information in connection with my injury or illness. This includes, but is not limited to, all records regarding my medical history, consultation, inpatient and outpatient treatment and diagnostic test results, both films and reports.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.)

_____ _____

Patient's Name (Please Print) Social Security Number

_____ _____

Patient's Signature Date

EMPLOYEE ACKNOWLEDGEMENT

UNDER SECTION 306 (f.1) (1) (I) OF THE PA WORKERS' COMPENSATION LAW

I, _____, recognize and agree that my employer has posted a list of at least six (6) healthcare providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO's). I further agree that my employer has provided the name, address, telephone number and area of medical specialty of each designated provider on the list. I also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306 (f.1) (1) (I) of the Pennsylvania Workers' Compensation Act. My rights and duties include, but are not limited to, the following:

I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for ninety (90) days from the date of the first visit to a designated provider. As long as treatment is obtained from a designated provider during the 90-day period, my employer will pay all reasonable medical treatment and supplies related to the injury;

I have the right to switch from one designated health care provider on the list to another during the 90-day period and my employer must pay for this treatment;

If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider;

I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the 90-day period;

I have the right during the 90-day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services;

After the expiration of the 90-day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.

If I treat with a non-designated health care provider after the expiration of the 90-day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for the treatment rendered by the non-designated provider prior to notification; and

If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any heath care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the procedure shall be performed by one or more of the designated health care providers for a period of 90 days from the date of the visit to my health care provider (date of examination of the additional opinion).

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

_____ _____

Date Employee Signature

_____ _____

Date Witness

Williamsport - Lycoming (17701)
(4/26/2022)
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
The Work Center at UPMC Susquehanna Williamsport	1100 Grampian Blvd FL 1. Williamsport, PA 17701	570-320-7444	Occupational Medicine
Disa, Inc	2605 Reach Rd Williamsport, PA 17701	570-327-8790	Occupational Medicine
Sun Orthopaedics of Evangelical	435 River Ave Williamsport, PA 17701	800-598-5096	Orthopedics
UPMC Susquehanna Health Orthopedics	1705 Warren Ave Ste 101 Williamsport, PA 17701	570-321-2020	Orthopedics
UPMC Susquehanna General Surgery at Williamsport	740 High St Ste 1003 Williamsport, PA 17701	570-321-3160	General Surgery
The Eye Center of Central Pennsylvania	435 River Ave Williamsport, PA 17701	866-995-3937	Ophthalmology
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Pharmacy
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Durable Medical Equipment
MedRisk	Call Toll Free for Scheduling	1-855-572-3926	Physical and Occupational Therapy 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	Durable Medical Equipment
Homelink	Call Toll Free for Closest Location	1-800-571-2943	Durable Medical Equipment

KEYSCRIPTS

Live-Operator Support 866.446.2848
Email info@keyscriptsllc.com
Visit keyscriptsllc.com
Fax 717.732.9467

Dear Injured Worker:

The attached temporary KeyScripts Prescription Benefit Card will authorize you to obtain prescription medications related to your work injury, with no out-of-pocket expense, **but you must call to activate the card before taking it to the pharmacy**. The call takes only a few minutes. You will be asked for your name, date of birth, employer's name and telephone number, and your date of injury, so please have this information available when you call.

CALL 866.446.2848 TO ACTIVATE YOUR CARD NOW

YOUR ACCOUNT NAME IS: EASTERN ALLIANCE

Write your name and Employee ID number (provided to you during card activation) in the spaces provided on the card. Your card will be immediately activated after your call, and you may then take it to your pharmacy to fill your work injury prescription(s). *NOTE: There may be limitations on how much of your prescription can be filled, based on your employer's prescription benefit plan.*

Do not attempt to fill any prescription other than your work injury prescription using the KeyScripts card. Avoid filling any prescription related to your work injury directly at the prescribing physician's office, as most physicians do not accept prescription benefit cards similar to KeyScripts' for billing purposes.

You may visit your KeyScripts network pharmacy of choice, which includes all of the major retail pharmacies, such as CVS, Rite Aid, Target, Walgreens and Walmart. **Need help finding your nearest network pharmacy? Call KeyScripts at 866.446.2848.**

Your temporary KeyScripts Prescription Benefit Card contains important claims and customer service information for you and your pharmacist. After activation, present the card to your pharmacist when filling any prescription related to your work injury. You will receive a permanent card in the mail shortly.

KEYSCRIPTS **For customer service, call 866.446.2848** **Bin #: 009430** **Group ID: EAST0030** ProCare Rx **Employee Name:**_____ **Employee ID:** _____ ***Workers' Compensation Prescription Benefit Card***	**To the Employee:** Present this card to your pharmacy of choice for any prescription drug related to your worker's compensation injury. This card is for identification purposes only, and your pharmacist may require additional/photo identification at time of fill. Unauthorized or fraudulent use of this card is punishable by law. We reserve the right to revoke this card at any time. **To the Pharmacy:** Submit claims via the ProCare System only for the person for whom the prescription was written. ProCare RX 1267 Professional Parkway, Gainesville GA 30507 **Pharmacy Help Desk 1.800.277.1657**

"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION
[To be completed by Employee]

Name (First, Last)	Date of Birth / /	Social Security Number
Address: (Street, City, State, Zip)		
Phone Number(s): Home: ( ) Other: ( )		
Job Title:	Department:	Shift:
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:	
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM
Accident was reported to:		Worked Until End of Shift ☐YES ☐ NO

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ **Arm**	☐ **Face**	☐ **Groin**	☐ **Internal Organs**	☐ **Neck**	☐ **Wrist**
☐ **Back**	☐ **Finger**	☐ **Hand**	☐ **Leg**	☐ **Elbow**	☐ **Shoulder**
☐ **Eye**	☐ **Foot/feet**	☐ **Head**	☐ **Knee**	☐ **Stomach**	☐ **Other (describe)**

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true. Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act165.

Employee Signature: **Date:**
Original Signature Required.

SUPERVISOR
ACCIDENT INVESTIGATION REPORT

SUPERVISOR REPORT
[To be completed by the employee's direct supervisor]

Date of Accident / /	Employee's Name (First, Last)	
Supervisor Name:	Department / Location:	

Was this the employee's usual occupation?
☐ Yes ☐ No If No, Describe.

Was the employee performing a normal job task?
☐ Yes ☐ No If No, Describe.

Do you have any reason to believe this employee's injury did not occur at work?

☐ Yes ☐ No If Yes, List the Reasons:

Time in occupation.

☐ Less than 1 month
☐ 1 to 5 months
☐ 6 months to 5 years
☐ More than 5 years

Treatment.

☐ First-Aid (In-House)
☐ Emergency Room (Hospital)
☐ Clinic or Doctor's Office

Name of Clinic or Doctor:

ACCIDENT INVESTIGATION

Accident Sequence
Instructions: Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury and moving back in time, reconstruct the sequence of events that led to the injury.

❶ Injury Event
❷ Accident Event
❸ Preceding Event 1
❹ Preceding Event 2
❺ Preceding Event 3

Describe the Accident:

Injury Classification

Nature of Injury:

☐ Slip / Fall
☐ Strain
☐ Sprain
☐ Struck Against
☐ Struck By
☐ Puncture
☐ Caught in/or between
☐ Overexertion
☐ Contact with Electrical Current
☐ Burn
☐ Other (describe)
☐ Fall from Elevation
☐ Fall from Same Level

Type of Injury:

☐ Abrasion	☐ Crush Injury	☐ Sprain	☐ Inhalation	☐ Other: (describe)
☐ Amputation	☐ Eye - Foreign Body	☐ Puncture	☐ Dermatitis	
☐ Burn	☐ Fracture	☐ Infection	☐ Repetitive Motion	
☐ Contusion	☐ Laceration	☐ Illness	☐ Tendonitis	

Accident Sketch and/or Photograph(s) (Attach)

Witness(s) Interviews:

(1) Name:
Phone Number:
Statement:

(2) Name:
Phone Number:
Statement:

Casual Factors (Check all factors that contributed to the accident)

- ☐ Unsafe Act
- ☐ Failure to Follow a Standard Operating Procedure
- ☐ Failure to Comply with Direction
- ☐ Hazardous Work Condition
- ☐ Failure to use Personal Protective Equipment
- ☐ Improper use of Equipment and/or Machinery
- ☐ Equipment Malfunction
- ☐ Failure to work at a safe speed/pace
- ☐ Improper body mechanics (i.e. unsafe lifting technique)
- ☐ Unsafe work environment or condition
- ☐ Failure to obey safety policy
- ☐ Inadequate training
- ☐ Horseplay
- ☐ Other:

Comments:

Corrective Actions (corrective actions must be listed for all accidents)

- ☐ Retrain Employee (s)
- ☐ Implement a new or revised job procedure
- ☐ Repair or Modify Equipment or Machinery
- ☐ Use additional Protective Equipment
- ☐ Install Machine Guarding
- ☐ Other. (Please Describe Below)

PROPOSED COMPLETION DATE:

Comments:

Supervisor Signature: Date:

"WITNESS" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]			
Name (First) of witness	(Last)	(Middle initial)	
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:		
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	
Accident was reported to:			

Description of Accident (Describe how the injury occurred, be specific) (include body parts assumed to be injured)

Drawing of Accident:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.
Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of the law and may also be subject to criminal and civil penalties.

Witness Signature: **Date:**
Original Signature Required.