

COUNTY OF ALLEGHENY

EMPLOYEE WORK ACCIDENT REPORT

County Employees: This form is used to report a work-related accident, illness, or injury. Seek medical treatment from a Workers' Compensation Health Care Panel Provider and take the KeyScripts Pharmacy Card with you. These two documents are found in the Employee Work Accident Report Packet. Report the claim by phone to WorkPartners at 855-396-8762, available 24/7. At the end of the call, a claim number will be generated for billing purposes. Follow-up by faxing this form to both WorkPartners:412-667-7111 and Allegheny County Safety:412-350-5888 within 48 hours.

Section 1: EMPLOYEE Completes this Section-Please Print

Employee Name _____
Last First MI

Department _____ Employee Supervisor _____
(Please include First and Last Name/Title/Phone Number)

Date of Accident/Symptoms ___/___/___ Time: ___ AM/PM Shift: ___-___
(If you feel this is a recurrence of a previous injury/illness, please indicate original accident date here: ___/___/___)

Social Security # ___-___-___ Employee Phone ___-___-___

Employee Address _____
Street City State Zip County

Date of Birth ___/___/___ Male/Female Married/Single # of Dependents ___

Job Title _____ Hire Date ___/___/___ Years on this job _____

Employment Status: Full-time Part-time Seasonal Volunteer Other

Date you notified employer ___/___/___ Who did you notify? _____
(Please include First and Last Name/ Title/ Phone Number)

Were there any witnesses to your accident? NO YES (If yes, please give Names/ Phone Numbers to your Supervisor)

Where did the accident happen? _____

Describe the Accident and Body Part(s) affected: (Please be as DETAILED as possible.)

Did you plan to receive medical treatment at this time? NO YES
If no, please notify EHN/ Nursing Supervisor **immediately** if condition changes and/or further evaluation is needed.
If yes, where and when did you receive treatment? _____

Have you ever had an illness or injury to this part(s) of your body in the past? NO YES Date ___/___/___
If yes, do you feel that you were completely recovered prior to this current illness or injury? Please fully explain.

Employee Signature* _____ Date ___/___/___

*My signature verifies that the information I provided is true and correct to the best of my knowledge. My signature also confirms that I have received a copy of Allegheny County's: Workers' Compensation Health Care Panel Providers.

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EMPLOYEE WORK ACCIDENT REPORT- PAGE 2

Section 2: SUPERVISOR/WORKER'S COMPLIAISON Completes this Section -Please Print

Supervisor/ Acting Supervisor's Name/ Title _____ Phone _____
Supervisor's Description of Accident: (Please be as DETAILED as possible.)

List any witnesses reported by the Employee and their Phone Numbers _____

Initial Treatment: (check all that apply)

- Refused treatment or not planning to seek treatment at this time.
- Minor (band aid, aspirin, etc.)
- Medical treatment on the Employer's Panel – Location and Date _____
- Medical treatment at an Emergency Room – Hospital and Date _____ EMSTransport? NO YES
- Medical treatment NOT on the Employer's Panel – Location and Date _____

Did the employee leave their work shift to seek medical treatment? NO YES

IF KNOWN:

Is employee off work due to the injury? NO YES

Last Date Worked _____ Date Disability Began _____ Return to Work Date, if known _____ Did not miss any time _____
 If the employee has been released to return to work, is he/she working modified duty? _____
 Can you accommodate the work restrictions? _____

Section 3: SUPERVISOR/ MANAGER Completes this Section
Accident Investigation and Analysis -Please Print

Was the accident caused by a slip, trip, or fall? NO YES If yes, specify the location _____

Is this a motor vehicle accident? NO YES

Are formal safety procedures in place for the task that contributed to the accident? NO YES

If applicable: List any personal protective equipment (PPE) provided for safety: _____

Is the Accident Investigation completed? NO YES (If no, please state why not. _____)

Action taken/ Plan of Action to rectify or prevent reoccurrence (MUST BE COMPLETED): _____

Supervisor/ Acting Supervisor Signature* _____ Date ____/____/____

*My signature verifies that the information I provided is true and correct to the best of my knowledge.

Claim Number: _____ Reported Date ____/____/____ Time ____:____ AM/PM

Reported By _____

SEND COMPLETED FORM TO BOTH:
 WORK PARTNERS, County Claims Unit by FAX (412)667-7111 and to
 ALLEGHENY COUNTY SAFETY by FAX (412)350-5888

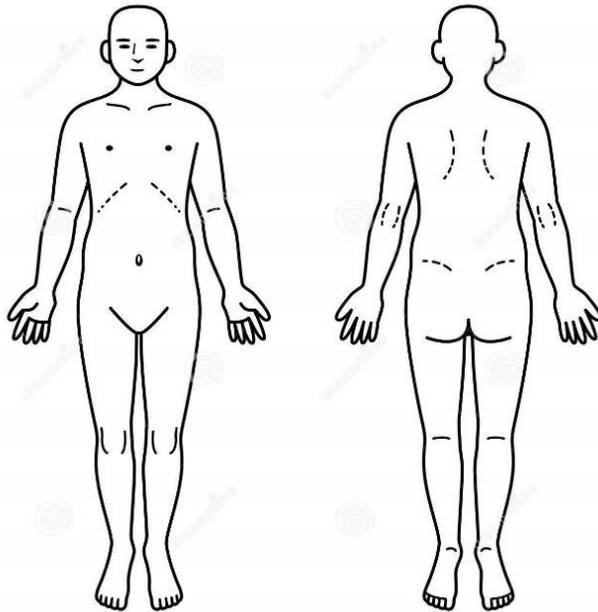
TO BE COMPLETED BY SUPERVISOR/ MANAGER-Please Print

Initial Medical Assessment:

Indicate the location of the injury on the diagram: Temperature Pulse Respiration (TPR) _____
Blood Pressure (BP) _____

Type of Injury:

- 1. Abrasion
- 2. Burn
- 3. Contusion
- 4. Exposure
- 5. Hematoma
- 6. Laceration
- 7. None Apparent
- 8. Other
(Specify) _____



ACCIDENT

- 1. Fatal
- 2. Non-Fatal

Claimant referred to Panel Physician _____

Return to Work _____

Sent to Hospital _____

Additional Comments:

SEND COMPLETED FORM TO BOTH:

WORK PARTNERS, County Claims Unit by FAX (412)667-7111 and to ALLEGHENY COUNTY SAFETY by FAX (412)350-5888

County of Allegheny
Workers' Compensation Health Care Panel Providers
Updated November 15, 2019

TO REPORT A WORK INJURY OR ILLNESS CALL 1-855-396-8762 24 hours a day, 7 days a week

IN COMPLIANCE WITH THE PENNSYLVANIA WORKERS' COMPENSATION LAW, ACT-44 7 ACT-57, THIS IS TO NOTIFY YOU THAT IN THE EVENT OF A WORKER RELATED INJURY OR ILLNESS, YOU MUST REPORT YOUR INJURY AND USE THE SERVICES OF ONE OF THESE DESIGNATED HEALTH CARE PROVIDERS.

Employees must seek care with a Health Care Provider on this list for the first 90 days of treatment, which include follow up appointments and referrals to a specialist.

Name	Address	Phone	Hours of Operation / Locations
INITIAL CARE SITES - Occupational Medicine			Also can provide treatment for Blood Borne Pathogen Exposures
Concentra Medical Center - West End Christopher Emond MD (Orthopedic)	1600 West Carson Street, Suite 200 Pittsburgh, PA 15219	412-391-1137	Monday - Friday 7:00AM to 5:00PM Walk-in appointments available for initial visit only Physical Therapy available onsite
Concentra Medical Center - Aspinwall	15 Freeport Road, Ste. 100 Pittsburgh, PA 15215	412-784-1678	Monday - Friday 7:00AM to 7:00PM Walk-in appointments available for initial visit only Physical Therapy available onsite
Concentra Medical Center - Oakland	120 Lytton Ave, Ste. 275 Pittsburgh, PA 15213	412-621-5430	Monday - Friday 8:00AM to 5:00PM Walk-in appointments available for initial visit only Physical Therapy available onsite
Concentra Medical Center- Robinson	4390 Campbell's Run Road Pittsburgh, PA 15205	412-429-9675	Monday - Friday 8:00AM to 5:00PM Walk-in appointments available for initial visit only Physical Therapy available onsite
St. Clair Occupational Medicine (Inside Urgent Care) Christopher Maropis, MD	St. Clair Hospital - Outpatient Ctr. 200 Oxford Drive, Ste. 100 Bethel Park, PA 15102	412-942-7115	Monday - Friday 9:00AM to 5:00PM By appointment only Physical Therapy available onsite
INITIAL CARE SITES - MedExpress (Initial Visit Only)			
MedExpress - Monroeville Route 48	2644 Mosside Blvd. Monroeville, PA, 15146	412-372-5649	7 Days/week 8:00AM to 8:00PM Walk-in appointment available
MedExpress - Monroeville Penn Center	3433 William Penn Hwy Pittsburgh, PA 15235	412-825-3627	7 Days/week 8:00AM to 8:00PM Walk-in appointment available
MedExpress - Shadyside/Bloomfield	5201 Baum Blvd. Pittsburgh, PA 15224	412-687-3627	7 Days/week 8:00AM to 8:00PM Walk-in appointment available
INITIAL CARE SITES - Urgent Care (Initial Visit Only)			
Steel Valley Express Care	4630 Browns Hill Road Pittsburgh, PA 15217	412-421-1000	7 Days / week 8:00AM to 8:00PM Walk-in appointments available

Specialty Medical Services - By appointment only

Name	Address	Phone	Hours of Operation / Locations
OPHTHALMOLOGY			
Laurie Ann Roba, MD	1326 Freeport Rd. Ste. 200 Pittsburgh, PA 15238	412-963-0414	By appointment only
Eye Physicians & Surgeons Drs. Christ Balouris	St. Margaret's Med Arts Bldg. 200 Delafield Rd., Ste. 2020 Pittsburgh, PA 15215	412-784-9060	By appointment only Other locations in Shadyside & Wexford
NEUROSURGEON			
University of Pittsburgh Physicians Adam Kanter & Daniel Wecht	UPMC Presbyterian Hospital 200 Lothrop St., Ste. A-402 Pittsburgh, PA 15213	412-647-3685	By appointment only Other locations available 1-866-804-5282 Bethel Park, Wexford, Monroeville, McMurray, Shadyside & McKeesport
NEUROLOGY - Concussion Screening			
Associates In Neurology of Pittsburgh Richard Kasdan, MD	665 Rodi Road, Suite 103 Pittsburgh, PA 15235	412-241-7380	Other location - Jefferson Hospital
CHIROPRACTOR			
William Marino, DC	507 Greenfield Avenue Pittsburgh, PA 15207	412-421-3060	By appointment only
Frank Imbarlina, DC	1720 Washington Rd, Ste. 201 Pittsburgh, PA 15241	412-833-6323	By appointment only
MRI & DIAGNOSTICS			
PCS Imaging Network	Multiple Facilities & Locations	1-888-594-4001	By appointment only
PHYSICAL THERAPY			
PCS Physical Therapy Network	Multiple Facilities & Locations	1-888-594-4001	By appointment only
Concentra <i>(for Concentra patients only)</i>	Same locations as Occupational Medicine Offices	See Occupational Medicine	By appointment only
Tri State Physical Therapy <i>(for Tri-State Orthopedic patients only)</i>	Same locations as Orthopedic Offices	See Orthopedics	By appointment only
PHARMACY & DURABLE MEDICAL EQUIPMENT			
KeyScripts <i>Your temporary pharmacy card is now a part of your Employee Accident Report Packet- please obtains from your supervisor.</i>	Multiple pharmacies in network	1-866-446-2848	No deductible or co-payment
You must continue to receive treatment from one of the DESIGNATED HEALTH CARE PROVIDERS from the list above for a period of ninety (90) days from the date of your first visit. If one of the DESIGNATED HEALTH CARE PROVIDERS refers you to another licensed specialist, your employer will pay the bill for this service if reasonable, necessary and causally related to your work injury/illness. If you are faced with a medical emergency, you may secure treatment from the nearest hospital and your employer will pay for the emergency services if reasonable & necessary and causally related to your work injury/illness. If follow-up medical treatment is required following your visit at the hospital, you must use the services of one of the DESIGNATED HEALTH CARE PROVIDERS listed above for that follow-up treatment for the 90-day period.			

<p>Workers' Compensation Administrator & Billing Address: UPMC WorkPartners Claims Management Services P.O. Box 2971 Pittsburgh, PA 15230</p>	<p>To report an injury, obtain billing information or other inquiries: 1-855-396-8762 Fax: 412-667-7111 Email: WPACServiceAcct@upmc.edu</p>
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1970 Technology Parkway, Mechanicsburg PA 17050
Phone 866.446.2848 Visit www.keyscripstsllc.com
Email info@keyscripstsllc.com Fax 717.732.9467

PHARMACY CARD – ALLEGHENY COUNTY WORKERS’ COMPENSATION

Here is your KeyScripts Prescription Benefits Card containing important claims and customer service information for prescription drugs related to your workers’ compensation injury. You or your employer must call to activate the card before you take it to the pharmacy. After activation, detach the lower portion of this letter and present it to your pharmacist when filling your prescription.

**Call 866.446.2848 TO ACTIVATE YOUR CARD
AND/OR TO FIND A PARTICIPATING PHARMACY.
YOUR ACCOUNT NAME IS: ALLEGHENY COUNTY/UPMC**

You may visit the KeyScripts network pharmacy of your choice, which includes CVS, Rite Aid, Target, Walgreens, Walmart and other retail pharmacies. You can quickly find a participating pharmacy by using the pharmacy search on the home page at www.keyscripstsllc.com.

Please note:

- The prescription(s) must be related to your work injury.
- There may be limitations on how much of your prescription can be filled.
- Use a KeyScripts Retail Pharmacy to ensure your prescription(s) will be filled with no out-of-pocket expense.

Detach Here

 <p>For customer service, call toll free, at 1.866.446.2848</p> <p>Bin #: 009430 Group ID: UPMC0030</p> <p>Employee Name: _____</p> <p>Employee ID: _____</p> <p><i>Workers’ Compensation Prescription Benefits Card</i></p>	<p>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.</p> <p>To the Pharmacy: Submit claims via the ProCare System only for the person for whom the prescription was written.</p> <p style="text-align: center;">ProCare PBM 3090 Premiere Parkway, Suite 100 Duluth, GA 30097 Pharmacy Help Desk 1.800.277.1657</p>
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HOW TO REPORT A WORK INJURY

Employee Responsibilities:

1. Report work related injury/illness **immediately** to a supervisor or designee.
2. Seek medical treatment, if needed - see below.
3. Within 24 hours-complete the Employee Accident Report Packet obtained from your supervisor/designee. Complete section 1 of the Employee Accident Report Form, Rights and Responsibilities, and the Release of Records sign all and give it to your supervisor/designee who will report the incident to Work Partners. Work Partners will assign a claim number which will be used for billing purposes.
4. Take the information that is attached to the packet, i.e., panel providers, key script card (medication/pharmacy needs), and the worker's comp claim adjuster phone numbers.

Medical Treatment:

When medical help is required, the employee should seek treatment with one of the panel providers. Walk-in clinics are available.

Employees who suffer non-emergency injuries such as strains, sprains, and cuts should report to a health care Panel Provider and follow up with that provider for the first 90 days of treatment. If an employee chooses a provider who is not on the panel, per Pennsylvania workers compensation law the county has no obligation to pay for treatment. If the incident occurs evenings or weekends when the panel providers are closed, report to the nearest hospital emergency department and follow up with a panel provider on the next business day.

Employees should report all injuries no matter how small.

Supervisor Responsibilities:

If the employee needs medical treatment:

1. Arrange for the employee to seek treatment with a Panel Provider, this list is in the accident report packet the employee should have completed. **Assure you give the employee the doctor listing, claims adjuster phone numbers and key script card (for medication/pharmacy needs).** Encourage employees to seek treatment with Concentra Medical Providers during business hours, no appointment is needed. If emergency treatment is needed direct the employee to the nearest hospital emergency room.
2. Complete your section of the injury report, attach any supplemental reports relating to the injury/incident, and call the below number to report the injury
3. Instruct the employee to contact the jail administration office as soon as possible after being treated for the injury.

Call 1-855-396-8762 as soon as possible or within 24 hours to report the occurrence to Work Partners. The line is staffed 24 hours a day, 7 days a week. This step generates a claim number for the incident.

Complete Section 2 of the Employee Accident Report. If the injury results in medical treatment and/or lost time also complete Sections 3 & 4 and conduct an accident investigation. Record the Name(s) and contact information of witnesses. Forward the completed Employee Work Accident Report to the administration office ASAP.



ALLEGHENY COUNTY WORKERS' COMPENSATION
RIGHTS AND RESPONSIBILITIES
EMPLOYEE NOTICE

REMEMBER - IT IS IMPORTANT TO TELL YOUR SUPERVISOR
ABOUT YOUR INJURY IMMEDIATELY NO MATIER HOW MINOR YOU THINK IT MAY BE.

I, (print name), understand that my employer has selected a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than two (2) of which are coordinated care organizations (CCO). My employer has provided the name, address, telephone number and area of medical specialty of each designated provider on the list. This provider list is posted within my department, work site, and/or is available through my supervisor.

I understand I MUST immediately report an injury to my supervisor. If any injury requires medical treatment, I must contact my employer within twenty-four (24) hours of such treatment and inform him/her of the nature of my injury and the treating physician's diagnosis and treatment plan.

I also acknowledge that I have been presented with this written notice setting forth my rights and responsibilities under Section 306 (f.1)(l)(i) of the Pennsylvania Workers' Compensation Act. My rights and responsibilities include the following:

1. 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;
2. As long as treatment is obtained from a designated provider, all reasonable and necessary medical supplies and treatment related to the injury will be paid by my employer;
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for reasonable and necessary treatment causally related to my work injury/illness;
4. 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 ninety (90) day period;
5. I have the right during the ninety (90) day period from initial treatment with a designated provider, to seek medical treatment from a non-designated provider but I understand that my employer is not responsible to pay for these services;
6. After the expiration of the ninety (90) day period from initial treatment with a designated provider, I have the right to seek treatment from any health care provider and my employer must pay for such treatment if it is reasonable, necessary, and causally related to my work injury/illness;
7. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer and third-party administrator with 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 treatment rendered by the non-designated provider prior to notification.
8. I understand my bills will be paid IF the services provided are reasonable, necessary, and causally related to my work injury/illness, and my licensed physician or practitioner of the healing arts provides reports as stipulated. These reports must be filed with my employer or third-party administrator within ten (10) days after my first visit and at least once a month for as long as treatment continues.
9. If a designated provider recommends invasive surgery, I understand that I may obtain a second opinion from a non-panel provider. Should I elect to follow the treatment plan recommended by the non-panel provider, I understand that I must obtain that treatment from a panel provider for ninety (90) days from the date of the appointment with the non-panel provider.
10. I understand that if one of the panel providers refers me to another licensed specialist, my employer will pay the bill for these services if reasonable, necessary and causally related to my work injury/illness.

As an employee of Allegheny County, I hereby acknowledge that I have been given the opportunity to review the Allegheny County Compensation Rights and Responsibilities and list of Designated Health Care Providers. My signature reflects my understanding of my medical treatment rights and duties with regard to work-related injuries and occupational illnesses.

Employee Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the PA Workers' Compensation Act and may also be subject to criminal and civil penalties through PA Act 165.

NOTICE: To be placed in Employee's Personnel File (Copy must be provided to Employee)



COUNTY OF ALLEGHENY

DEPARTMENT OF HUMAN RESOURCES

920 CITY-COUNTY BUILDING • 414 GRANT STREET
PITTSBURGH, PA 15219
PHONE (412) 350-6830 • FAX (412) 350-5230
WWW.ALLEGHENYCOUNTY.US

AUTHORIZATION FOR RELEASE OF RECORDS AND REPORTS

I, the undersigned, authorize any healthcare provider or facility, physician or nurse who has attended me, or any hospital at which I have been confined, to furnish to my Employer, the County of Allegheny, its representatives WorkPartners Business Management Services, the law firm of O'Brien, Rulis, & Bochicchio, and any other County representative or designees, all available information concerning my physical or psychiatric condition and treatment, including examination and duplication of x-rays or other diagnostic films taken of me.

Medical records are defined by state regulation as all "clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents." This includes diagnostic test results, x-rays, physician notes, and any records from prior treating or consulting physicians.

Additionally, this authorization allows for release of all billing information for treatment related to my work injury, should such information be specifically requested.

This authorization also pertains to any vocational, employment, or educational information that may be needed in the management of my work-related claim and rehabilitation efforts.

A photocopy of this authorization is to be given the same force and effect as the original. This authorization shall be valid for the duration of my disability claim(s).

Signature: _____ Date: _____

Print Name: _____

Social Security Number: _____

Date of Birth: _____

ATTENTION MEDICAL RECORDS OFFICE:

RETURN MEDICAL REPORTS AND RECORDS TO:

ALLEGHENY COUNTY CLAIMS

UNIT WORKPARTNERS

P.O. Box 2971

PITTSBURGH, PA 15230

PHONE 1-855-396-8762 • FAX 412-667-7111

Workers' Compensation Information

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 when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the 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 at:

Bureau of Workers Compensation
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501;
Telephone number within Pennsylvania: (800) 482-2383
Telephone number outside of PA Commonwealth: (717) 772-4447
TIY (800) 362-4228 (for hearing and speech impaired only)
www.state.pa.us,
PA Keyword: workers comp