

## Important Notice Regarding Change of Workers' Compensation Provider

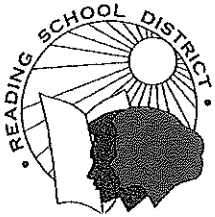
Effective July 1, 2016, Reading School District will no longer be utilizing Occupational Health Services as our Workers' Compensation Provider.

Our new provider is Worknet Occupational Medicine located at 3225 N. 5<sup>th</sup> Street Highway Reading, PA. In order to schedule an appointment, please contact them at 610-939-2391. Their hours of operation are Mon.-Thurs. 8-5 and Friday 7-4. Please note, the panel of physicians for follow-up care has also changed.

If you obtain an injury prior to July 1, 2016 or are currently being treated for a work-related injury, you are to continue treatment as directed by Occupational Health for that particular injury. As always, if you experience a work-related injury that requires emergent care, please proceed to the nearest hospital for initial treatment. All follow-up care must be coordinated by Worknet.

Each building will have new Workers' Compensation Injury Reports with additional information. You are to continue completing these forms within 24 hours of an injury. If you have any questions, please contact Denise Templin in the Benefits Office at 484-258-7025.





# READING SCHOOL DISTRICT

## Benefits Department

800 Washington Street, Reading, PA 19601-3691

(484) 258-7000

To All Employees:

As of July 1, 2009, the Reading School District has contracted with **Engle-Hambright & Davies, Inc. (EHD)** as our workers' compensation carrier. PMA is the third party administrator for all workers' compensation claims of the Reading School District. They handle all administrative and billing issues of the claims filed by our employees.

**Each work related incident is to be reported to your building principal, vice principal or supervisor as soon as possible. When an incident is reported to your supervisor; a workers' compensation form needs to be completed.**

Attached is the workers' compensation packet that is to be completed and returned to the Benefits Office. All forms are to be completed by the injured worker. The building principal, assistant principal or supervisor must sign the applicable pages of the claim report. Please make two (2) copies of all completed forms; one (1) for the injured worker's personal records and one (1) for the building records. The original completed claim should be sent to the Benefits Office.

**All completed workers' compensation claim packets are to be sent to the Benefits Office within 24 hours of the incident. Failure to do so may result in the delay of processing or denial of your claim.**

The claim will be filed once this report is received by the Benefits Office. If any information is needed by the injured worker, please contact the Benefits Office either by phone or email.

**If you feel you need medical care, please contact Worknet Occupational Medicine for an appointment. Worknet is located at 3225 N. 5<sup>th</sup> Street Highway, Reading. Their phone number is 610-939-2391. All appointments for medical care, physical therapy sessions or specialist referrals are to be scheduled before or after working hours. It is only your initial visit with Worknet that may be scheduled during work hours. Permission will not be granted to attend appointments during work hours unless the Benefits Office verifies with your provider of service that they do not have appointments available before or after your work day.**

**All medical care received within the first ninety (90) days of the work related injury must be with the Reading School District Panel of Providers. The Panel of Providers is included within this packet.**

If you have any questions, please do not hesitate to contact me at 484-258-7025.

Thank you,

Denise Templin, Benefits Coordinator  
Reading School District Benefits Office  
800 Washington Street  
Reading PA 19601  
610-371-5919 Fax  
484-25-7025 Phone

# READING SCHOOL DISTRICT- WORKERS COMPENSATION REPORT

<b>Workers' Compensation Report</b>											
Submit to Administration Building											
Denise Templin											
<b>Date Report Prepared</b>											
Month	Day	Year									

<b>Employee Social Security Number</b>											

<b>Date of Injury</b>											
Month	Day	Year									

<b>Employee First Name</b>											

<b>Employee Last Name</b>											

<b>Street Address</b>											

<b>City</b>				<b>State</b>				<b>Zip Code</b>			

<b>County</b>					

<b>Phone Number</b>											

<b>Employee</b>			<b>Number of Dependents</b>		
Male		Married			
Female		Single			

<b>Date of Birth</b>											
Month	Day	Year									

<b>Occupation or Job Title</b>											

<b>Employer</b>											
R	E	A	D	I	N	G	S	C	H	O	O
L	D	I	S	T	R	I	C	I	T		

<b>Street Address</b>											
8	0	0	W	A	S	H	N	G	T	O	N
S	T	R	E	E	T						

<b>City</b>				<b>State</b>				<b>Zip Code</b>			
R	E	A	D	I	N	G	P	A	1	9	6
0	1										1

<b>Full Day of Pay of Injury?</b>			
Yes		No	

<b>Time Employee Began Work</b>					
AM	PM				

<b>Time of the Occurrence</b>					
AM	PM				

<b>Last Day Worked</b>											
Month	Day	Year									

<b>Date Disability Began</b>											
Month	Day	Year									

<b>Date Employer Notified</b>											
Month	Day	Year									

<b>Date Returned to Work ( of applicable )</b>											
Month	Day	Year									

<b>Date of Hire</b>											
Month	Day	Year									

# READING SCHOOL DISTRICT- WORKERS COMPENSATION REPORT

Supervisor First Name									

Supervisor Phone Number											

Supervisor Last Name																			

Describe type of Injury or Illness																			

Parts of the Body Affected																			

Cause of Injury																			

Did the injury occur on County Property?	Of out of state indicate state
Yes <input type="checkbox"/>	No <input type="checkbox"/>

Were safeguards or safety equipment used?
Yes <input type="checkbox"/>
No <input type="checkbox"/>

List equipment, materials or chemicals employee was using when accident or illness exposure occurred

Describe how injury or illness/abnormal health condition occurred ( Describe sequence of events )

Initial Treatment ( check one )	
<input type="checkbox"/>	No Medical Treatment
<input type="checkbox"/>	Minor by Employee
<input type="checkbox"/>	Clinic / Hospital
<input type="checkbox"/>	Panel Physician
<input type="checkbox"/>	Employee Physician
<input type="checkbox"/>	Emergency Care
<input type="checkbox"/>	Hospitalized more than 24 hours

Supervisor First Name									

Supervisor Phone Number											

Supervisor Last Name																			



## WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

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

If you are faced with an immediate medical emergency, you may secure assistance from 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 do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide by same for 90 days.

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 the services rendered if such services are determined to have been unreasonable or unnecessary.

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.

**WORKER'S COMPENSATION**  
**EMPLOYEE NOTIFICATION**

**Part 2**

**Workers' Compensation Information**

(1) 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.

(2) 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.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) 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, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); [www.state.pa.us](http://www.state.pa.us), PA Keyword: workers comp.

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.

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS**

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at \_\_\_\_\_ for you to view. Also, you may get a copy of this list from \_\_\_\_\_

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below:

**MEDICAL TREATMENT: DURING THE FIRST 90 DAYS**

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

**IMPORTANT:** The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

**MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS**

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five (5) days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before signing this form.**

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

TIME OF HIRE                       WHEN I WAS INJURED                       OTHER

EMPLOYEE: \_\_\_\_\_ DATE: \_\_\_\_\_  
EMPLOYER REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_



## WORKERS' COMPENSATION INFORMATION

In Pennsylvania, 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, Pennsylvania 17104-2501  
Telephone number within Pennsylvania (800) 482-2383  
Telephone number outside of this Commonwealth (717) 772-4447  
TTY (800) 362-4228 (for hearing and speech impaired only)  
[www.state.pa.us](http://www.state.pa.us) - PA Keyword: workers comp.

## ACKNOWLEDGMENT

I, \_\_\_\_\_,  
employee of \_\_\_\_\_, hereby  
certify that I was provided with the above statement on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (date).

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Employer signature

## REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.
2. At least 3 of the health care providers on the list must be physicians.
3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCO's).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

**NOTE:** Your employer's list of health care providers must meet all of the above requirements. **If** the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

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BUREAU OF WORKERS' COMPENSATION  
HELPLINE INFORMATION CENTER  
1-800-482-2383 (Long-distance calls inside PA)  
1-717-772-4447 (Local and calls outside PA)

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## Policy of Worker's Compensation Claims

Any employee who sustains a work-related injury will have the following options. Please indicate your choice of pay and return as soon as possible to the Benefits Office in the Reading School District Administration Building;  
WHETHER OR NOT YOU LOSE ANY TIME FROM WORK as a result of your job-related injury.

In case of unprovoked assault upon an employee, sick leave pay will be paid automatically without the request of the injured person and will not be charged against his or her sick leave.

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As a result of the work-related injury or reported claim on \_\_\_\_\_, I will

- Keep the workers' compensation check and make no claim for sick days. Your WC claim compensation is 66 2/3% of your current salary. (Please keep in mind PSERS does not give credit for workers compensation days taken. PMA does not deduct the bi-weekly pension contributions from the WC claim check.)
- Take sick days and turn workers' compensation check over to employer. You will receive regular paycheck while you are out for your work related injury as long as employee has sick days. (Employee's bi-weekly PSERS contribution will continue as normal as long as there are sick days available.)
- Keep workers' compensation check & claim two (2) sick days per week. (Employee's PSERS contribution will be paid into the pension for the two (2) sick days taken per week.)

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)

# Workers' Compensation Temporary Prescription ID Card

## »» 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:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

## »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from 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 A4
- 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  
(enter in PA field in the format YYYYMMDD)

### 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 #: KVQA \_\_\_\_\_

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 Supervisor: Please fill in the information requested for the injured worker.

### Employee Information

\_\_\_\_\_ First M Last

\_\_\_\_\_ Street Address or PO Box

\_\_\_\_\_ City State ZIP

Employer Name

\_\_\_\_\_



EXPRESS SCRIPTS®



# NOTICE TO EMPLOYEES

Your employer has provided for the payment of benefits under the Workers' Compensation Act of this State  
IN CASE OF WORK-RELATED INJURY

- 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 prostheses, including training in their use.
- In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must immediately advise your supervisor of your injury, and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

### DESIGNATED PHYSICIANS

(Including address, telephone number, and area of medical specialty)

### CLINICS

†Worknet Occupational Medicine  
Occupational Medicine Clinic  
3225 N 5th Street Highway  
Reading, PA 19605  
610-939-2391  
Mon - Thurs - 8-5, Friday - 7-4

### PHYSICIANS/SPECIALISTS

†David Nowotarski, PT, DC  
Chiropractic  
43 Penn Avenue  
Sinking Spring, PA 19607  
610-678-8600

†Novacare Physical Therapy  
Physical Therapy  
3225 N 5th Street Highway  
Reading, PA 19605  
610-939-8330

†Orthopedic Associates of Reading  
Orthopedic Surgery  
301 S. 7th Avenue, Suite 3220  
West Reading, PA 19611  
610-378-8671

†Keystone Spine & Pain Management Center  
Neurosurgery  
2607 Keiser Blvd, Suite 200  
Wyomissing, PA 19610  
484-509-0840

†Reading Surgical Associates  
General Surgery  
2803 Keiser Blvd, Suite 104  
Wyomissing, PA 19610  
610-372-3824

†Reading Health Rehab Hosp  
Concussion Specialist  
2802 Paper Mill Road  
Reading, PA 19610  
484-628-2388

†Reading Health Systems  
Physical Therapy  
Various  
Locations, Please Call 484-628-8611

† = Denotes that the original provider record has been changed or a new record has been added.

**Express Scripts Pharmacy Program - To contact your local Express Scripts Pharmacy, please call (800) 897-9470**

The insurance company providing coverage for this business under the Workers' Compensation Law is: PMA Insurance Group

- You must continue to visit one of these persons listed above, if you need treatment, for ninety (90) day from the date of your first visit. If you do not, your employer may not be required to pay these services.
- After this ninety (90) day period, if you still need treatment and your employer had provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice, or your employer may not be required to pay for these services.
- Your bills will be paid for IF: your licensed physician or practitioner of the healing arts files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.
- If no list is provided as above, you may go to a licensed physician or practitioner of the healing arts of your choice.
- If one of the persons listed above refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.
- If you are faced with a medical emergency, you may secure assistance from a hospital or physician or practitioner of the healing arts of your choice.

Name: Reading School District

Address: 800 Washington Street Reading, PA 19601  
7104278

Generated: 05/12/2016  
Radius: 5 mile(s)

**REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY**

This material is provided for informational purposes only and is not meant to be legal advice. Any person reading or otherwise using the information contained herein acknowledges that the information is provided as a service and is not authorizing any specific treatment or course of treatment. Further, use of any provider listed does not verify or confirm coverage under the Workers' Compensation Act and PMA is not responsible for any losses incurred as a result of any person relying on this information.