

NOTICE TO EMPLOYEES

OF WORKERS' COMPENSATION INSURANCE FOR INDUSTRIAL INJURIES AND DISEASES

The undersigned, an employer subject to the provisions of the Workers' Compensation Act of Pennsylvania hereby gives notice to its employees and to all other persons interested, that is has secured the payment of the compensation payable to its employees and their dependents, by insuring with the **Housing and Redevelopment Insurance Exchange**.

Claims and requests for information are to be addressed to:

Excalibur Insurance Management Services, LLC
423 Jefferson Avenue
Scranton, PA 18510

Phone: (570) 961-5105

Fax: (570) 961-2178

Expiration Date of Policy – July 1, 2019

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

Attention School Districts

Do not jeopardize your financial or legal rights. Report all workers' compensation claims immediately.

The law requires wage loss claims be paid or denied within 21 days of the date of disability. Failure to comply with the 21-day period could result in legal penalties.

As a Housing and Redevelopment Insurance Exchange Compensation participant your claims are to be reported to:

Excalibur Insurance Management Services, LLC

423 Jefferson Avenue

Scranton, PA 18510

Phone: (570) 961-5105

Fax: (570) 961-2178

NORTHEASTERN ED IU #19 WORKERS' COMPENSATION PROGRAM PANEL OF PHYSICIANS LIST - WHEN YOU ARE INJURED AT WORK

You must select a physician from the list for the first 90 days under Workers' Compensation Act

MEDICAL PROVIDER	ADDRESS	TELEPHONE	SPECIALTY
EFFECTIVE 7/1/2017			
REGIONAL HOSPITAL OF SCRANTON	746 JEFFERSON AVENUE SCRANTON, PA 18510	570-348-7100	*EMERGENCY CARE
GEISINGER CMC	1800 MULBERRY STREET SCRANTON, PA 18510	570-969-8000	*EMERGENCY CARE
MID-STATE OCCUPATIONAL HEALTH SERVICES INC.	1000 MEADE STREET DUNMORE, PA 18512	570-209-7160	OCCUPATIONAL MEDICINE Dr. Mark Rainey
RAPID CARE @ NORTHEASTERN REHAB ASSOC.	5 MORGAN HIGHWAY STE 4 SCRANTON PA 18508	570-344-3788	OCCUPATIONAL MEDICINE Dr. Samuel Valenti
ORTHOPEDIC CONSULTANTS	909 SR 6 W TUNKHANNOCK, PA 18657	570-288-3535	ORTHOPEDICS
SCRANTON.ORTHOPEDICS/ COORDINATED HEALTH	344 MAIN STREET DICKSON CITY, PA 18519	570-307-1767	ORTHOPEDICS
CASEY BURKE, DO HAND SURGERY ASSOC.	232 SUNRISE AVE HONESDALE, PA 18431	570-877-2289	HAND SURGERY
PROFESSIONAL NEUROLOGICAL ASSOC. (MULTIPLE LOCATIONS)	235 MAIN STREET SUITE 115 DICKSON CITY, PA 18519	570-963-8803	NEUROLOGY
GEISINGER/VIEWMONT IMAGING	435 SCRANTON CARBONDALE HIGHWAY SCRANTON, PA 18508	570-343-4334	IMAGING/RADIOLOGY/MRI
ONE CALL CARE MANAGEMENT (OCCM)	FOR LOCATIONS AND APPOINTMENTS, PLEASE CALL	800-453-0574	PT, DME, DIAGNOSTIC STUDIES, HOME HEALTH
NORTHEASTERN EYE INSTITUTE (MULTIPLE LOCATIONS)	503 SOUTH STATE STREET CLARKS SUMMIT, PA 18411	570-587-5186	OPHTHALMOLOGY
ALLAN PERFILIO, DC PERFILIO CHIROPRACTIC	614 MORGAN HIGHWAY CLARKS SUMMIT, PA 18411	570-586-7778	CHIROPRACTIC CARE
STEVEN BROWN, DC BROWN CHIROPRACTIC	1767 QUINCY AVENUE DUNMORE, PA 18509	570-341-5544	CHIROPRACTIC CARE
MODERN MEDICAL/OPTUM	FOR PRESCRIPTIONS, PLEASE CALL	800-547-3330	**PHARMACY BENEFIT MANAGER***

* Follow Up with a Panel Occupational Medicine Provider for Continuing Treatment

** Pharmacy Benefit Manager for RX (Prescriptions).

*** Attempted Misuse of RX Card will be referred to Fraud Division.

REMINDER

In order to ensure that your medical treatment will be paid for by Excalibur Insurance Management Services, LLC., you must select from one of the physicians or providers as listed above.

You must continue to visit one of these physicians or other health care providers listed above, if you need treatment, for 90 days from the date of your first visit.

After this 90-day period, if you still need treatment, you may choose to go to another physician or health care provider for treatment. If this situation should arise, let your employer know and your Excalibur Insurance Management Services Representative know within 5 days of the first visit.

I have read all of the above regarding treatment for my Workers' Compensation Injury.

Employee Signature

Date

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 B. CAHERON STREET, ROOM 103
HARRISBURG, PA 17104-2601
(TOLL FREE) 800-402-2303
TTY (TOLL FREE) 800-302-4220

EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

____-____-____

DATE OF INJURY

____-____-____
MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

____-____-____

COUNTY

PHONE NUMBER

____-____-____

EMPLOYEE:

MALE MARRIED
FEMALE SINGLE

NUMBER OF DEPENDENTS

DATE OF BIRTH

____-____-____
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS

FT = Full-time
PT = Part-time

SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

NIETU

STREET ADDRESS

11200 LINE ST

CITY

ARCHIBALD

STATE

PA

ZIP CODE

118403

SIC CODE

EMPLOYER FEIN

24-60011023

PHONE NUMBER

570-876-9200

COUNTY

LACIKAWAINIA

NAICS CODE

FULL PAY FOR DAY OF INJURY?

YES
NO

TIME EMPLOYEE BEGAN WORK

____:____ AM
PM

TIME OF OCCURRENCE

____:____ AM
PM



LAST DAY WORKED

____-____-____
MONTH DAY YEAR

DATE DISABILITY BEGAN

____-____-____
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED

____-____-____
MONTH DAY YEAR

DATE RETURNED TO WORK

____-____-____
MONTH DAY YEAR

DATE OF HIRE

____-____-____
MONTH DAY YEAR

CONTACT FIRST NAME

CONTACT PHONE NUMBER

____-____-____

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work related injuries, illness, or "near miss" events (which could have caused and injury or illness) – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: <input type="radio"/> Injury <input type="radio"/> Illness <input type="radio"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="radio"/> Yes <input type="radio"/> No	
Date of injury/near miss:	Time of injury/near miss:
Name of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="radio"/> Yes <input type="radio"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="radio"/> Yes <input type="radio"/> No	
If yes, when?	Supervisor:
Your signature:	Date:

Supervisor's Accident Investigation Form

Name of Injured Person _____

Employee DOB _____ Employee SS Number _____

Employee Telephone Number _____

Employee Address _____

City _____ State _____ Zip _____

(Circle one) Male Female

What part of the body was injured? Describe in detail. _____

What was the nature of the injury? Describe in detail. _____

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools were being used? _____

Names of all witnesses:

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

Were safety regulations in place and used? If not, what was wrong? _____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

Supervisor Signature

Date

What to do if you are injured at work?

As soon as practicable, report the incident to your Supervisor and Human Resources to they can report it to our office, even if you don't think you need medical treatment.

- Make sure your employer has your most up-to-date contact information, including phone numbers, home address, and personal e-mail.

Your employer will file your claim with Excalibur Insurance Management, who will assign a representative to your claim to work with your going forward.

- If you require medical treatment, your employer will provide you with a claim number.
- When seeking medical attention for a work-related injury, tell the medical provider that yours is a Workers' Compensation injury.

Your employer should give you a copy of your Provider Panel.

****PLEASE NOTE****

If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

- Communicate any concerns about your treatment to your medical provider and to your Excalibur representative.

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(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.1)(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.1)(1)(I) and an acknowledgement 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 NEIU 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 the 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.1)(1)(I) and that I understand them to the extent that they are explained above.

Print Name

Employee Signature

Date

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.