PLEASE MAKE SURE THE EMPLOYEE KEEPS THIS DO NOT RETURN OR SCAN TO BENEFITS

EMPLOYEE: Please keep this form to have insurance information available to give to the workers' compensation provider if you seek or plan to seek medical attention.

Workers' Compensation Insurance Information:

INSERVCO

PO BOX 3899, HARRISBURG, PA 17101

1-800-356-0438

PRESCRIPTION INFO: If you are prescribed a prescription- DO NOT use your health insurance card. Contact The Benefits Dept. for a workers' compensation prescription card to use at the pharmacy.

Any questions regarding your workers' compensation medical bills should be directed to Inservco directly.

POCONO MOUNTAIN SCHOOL DISTRICT INCIDENT INVESTIGATION REPORT
FOR EMPLOYEE INJURIES ONLY

ORIGINALS ARE TO BE FORWARDED TO THE BENEFITS DEPARTMENT IMMEDIATELY

NO SCANS OR FAXES UNLESS URGENT

EMPLOYEE INFORMATION *- Please print or type.(This side to be completed by employee)*

NAME:_____
(Last) (First) (MI)

DATE OF BIRTH:_____ SEX: M F PHONE ( )_____ SOCIAL SECURITY #:_____

DATE OF HIRE:_____ JOB TITLE:_____ ASSIGNED BUILDING:_____

HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE:_____

COUNTY:_____ MARITAL STATUS:_____ NUMBER OF DEPENDENTS UNDER 18:_____

DATE OF INJURY:_____ TIME OF INJURY:_____AM/PM NORMAL START TIME_____

EXACT LOCATION/ADDRESS OF INCIDENT:_____

DESCRIBE HOW THE INCIDENT OCCURRED(WHAT WAS THE EMPLOYEE DOING AT THE TIME OF INCIDENT):_____

_____

_____

IDENTIFY PART(S) OF BODY INJURED: ***(BE SPECIFIC-LIST RIGHT/LEFT ETC.)*** _____

BE SPECIFIC ON WHAT INJURY EXAMPLE-LACERATION/CONTUSION/SPRAIN:_____

_____

_____

LIST ANY EQUIPMENT, MACHINERY OR CONTRIBUTING FACTORS TO THE INJURY(FACTS, NO OPINIONS):_____

_____

LIST OTHER EMPLOYEES INVOLVED AND/OR WITNESSES:_____

_____

ARE YOU EMPLOYED ELSEWHERE? YES OR NO IF YES,

NAME OF EMPLOYER:_____

ADDRESS:_____ PHONE #_____

DID YOU RECEIVE MEDICAL TREATMENT? Please circle: YES OR NO

IF YES, NAME OF PROVIDER: _____

ADRESSS: _____

_____

PHONE NUMBER: _____

I authorize any doctor, hospital, employer or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records which may be requested by Pocono Mountain School District and/or its representatives. By signing below I acknowledge receipt of the panel of workers' compensation providers dated 07/012017.

EMPLOYEE'S SIGNATURE:_____ EMAIL:_____

DATE:_____

FALSIFICATION OF INFORMATION COULD RESULT IN DISCIPLINARY ACTION AND/OR PROSECUTION.

POCONO MOUNTAIN SCHOOL DISTRICT INCIDENT INVESTIGATION REPORT

SUPERVISOR INFORMATION

EMPLOYEE'S NAME:_____

SUPERVISOR'S NAME:_____DEPARTMENT:_____

DATE INCIDENT WAS REPORTED TO YOU:_____

DID YOU WITNESS THE INCIDENT?: Y OR N

IS ANY INFORMATION PROVIDED BY THE EMPLOYEE INCORRECT TO YOUR KNOWLEDGE? Y OR N
IF YES, WHAT? _____

WHAT WAS THE EMPLOYEE DOING WHEN INJURED(Be specific. Identify tools or materials involved and explain how they were being used.)_____

_____

_____

DID INCIDENT RESULT FROM AN UNSAFE ACT?: Y OR N EXPLAIN:_____

WAS ACTION TAKEN TO PREVENT SIMILAR INCIDENT?:_____

DID INCIDENT RESULT FROM A HAZARDOUS CONDITION? Y OR N DESCRIBE:_____

WAS THE INJURY DUE TO DEFECTIVE EQUIPMENT? _____

WAS THE INJURY DUE TO THE CLAIMANT'S FAILURE TO USE A PROVIDED SAFETY DEVICE OR FAILURE TO FOLLOW KNOWN SAFETY RULE? Y OR NO IF SO, PLEASE DESCRIBE _____

DID CLAIMANT DELAY REPORTING INJURY TO SUPERVISOR? IF SO, EXPLAIN_____

DO YOU HAVE ANY CONCERNS ABOUT THIS INCIDENT? IF SO, EXPLAIN_____

_____

HAS EMPLOYEE LOST TIME FROM WORK?: Y N EXPLAIN:_____

IF YES, LAST FULL DAY WORKED:_____ HAS EMPLOYEE RETURNED TO WORK?: Y N

DATE EMPLOYEE RETURNED TO WORK:_____

HAS THE CLAIMANT HAD THIS TYPE OF INJURY BEFORE, AT WORK OR ELSEWHERE?
IF SO, EXPLAIN _____

I AGREE THAT THE ABOVE IS TRUE, CORRECT AND COMPLETE.

SUPERVISOR'S SIGNATURE:_____ TELEPHONE/EXTENSION:_____

DATE:_____

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider, however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for that first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another and that treatment will be paid for by your employer.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKER'S COMPENSATION ACT AS SET FORTH HEREIN.

DATE: _____

_____
Employee Name (Print)

_____
Employee Signature

Workers Compensation Panel of Providers

KEEP THIS LIST FOR YOUR RECORDS

If you suffer a work-related injury, immediately report the injury to your supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

- All treatment must be obtained from one of the healthcare providers listed below.
- You must continue to visit one of the healthcare providers listed below if you need treatment for 90 days from the date of your first visit. If one of the providers listed below refers you to another licensed specialist, those services will be paid.
- After this 90-day period, if you still need treatment, you may go to another healthcare provider for treatment as long as you notify your claims adjuster within five (5) days of your visit to a new provider.
- If a listed physician prescribes invasive surgery, you have the right to obtain a second opinion from a physician of your choice. If a second opinion differs from that of the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a detailed treatment plan. 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.

If you are faced with a medical emergency, you may secure initial emergency treatment from any emergency facility. However, when the emergency is resolved, follow-up treatment must be obtained from one of the following healthcare providers. If you choose to treat with an out-of-state provider, you may be subject to balance billing.

Several providers below have multiple locations-
treatment can be obtained at any of the locations for the listed providers

NAME OF PROVIDER	ADDRESS	CITY, STATE, ZIP	PHONE	SPECIALTY
Lehigh Valley Orthopedic Institute	505 Independence Road	East Stroudsburg, PA 18301	877.247.8080	General Practice
St. Luke's General Surgery Associates	208 Lifeline Road	Stroudsburg, PA 18360	484.526.2200	General Surgery
Geisinger- Neurology	1000 East Mountain Blvd.	Wilkes Barre, PA 18711	570.808.7300	Neurology
St. Luke's Neurology Associates	3 Parkinsons Road	East Stroudsburg, PA 18301	272.212.0553	Neurology
Advanced Eye Care Specialists	2055 Route 611	Swiftwater, PA 18370	570.839.2221	Optometry
St. Luke's Occupational Medicine	200 St. Luke's Ln-Suite 201	Stroudsburg, PA 18360	272.212.1024	Occupational Med
Mountain Valley Orthopedics	600 Plaza Court C	East Stroudsburg, PA 18301	570.421.7020	Orthopedics
St. Luke's Orthopedic Care	200 St. Luke's Ln-Suite 200	Stroudsburg, PA 18360	484.526.1735	Orthopedics
St. Luke's Spine & Pain Associates	3 Parkinsons Road	East Stroudsburg, PA 18301	484.526.7246	Pain Management
Allied Rehabilitation	150 Mundy Street	Wilkes Barre Twp, PA 18702	570.826.3900	Physical Therapy
Lehigh Valley Rehabilitation Center	100 Community Dr., Ste. 105	Tobyhanna, PA 18466	570.839.9975	Physical Therapy
Physical Therapy at St. Luke's	208 Lifeline Road, Ste. 104	Stroudsburg, PA 18360	570.664.8780	Physical Therapy
Back 2 Health Chiropractic	2369 Route 715	Tannersville, PA 18372	570.629.9507	Chiropractic
Corrective Chiropractic(Dr. Peechatka)	3199 Route 611	Bartonsville, PA 18321	570.629.6829	Chiropractic
Family&Sports Chiropractic(Dr. Simeone)	18 Fork Street	Mount Pocono, PA 18344	570.839.9402	Chiropractic

All of your healthcare provider bills and reports need to be sent to the following address for review and payment in accordance with the Pennsylvania Workers' Compensation Act

Inservco Insurance Services, Inc., P.O. Box 3899, Harrisburg, PA 17105-3899
Phone: 1.800.356.0438 Fax: 1.866.356.0438