Absence Management
Penn State Human Resources
The 331 Building, Suite 136
University Park, PA 16802
Phone: (814) 865-1782
Fax: (814) 863-6227
absence@psu.edu

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

ALL employees who experience ANY type of injury must complete this ENTIRE Workers' Compensation Signature Packet in addition to reporting ANY injury using:

Online system link located at http://hr.psu.edu/workers-compensation
or the Call Center at 1-877-219-7738

1. Workers' Compensation Employee Notification Form – ***required***
2. Employee Description of Injury Form – ***required***
3. Workers' Compensation Information Sheet – ***required***
4. Medical Records Release Authorization – ***required***
5. KEYSCRIPTS Pharmacy Program – ***employee copy***
6. 3 for 1 Selection Form – ***required if selecting 3 for 1 benefit (tech service employees must be hired prior to 7/1/2014, PSUPOA employees hired prior to 4/1/2019)***
7. Authorization for Alternative Delivery of Compensation Payment (LIBC-10) – ***required if selecting 3 for 1 benefit***
8. Health Care Panel Provider / (Penn State Extension Employee Panels) – ***employee copy*** (Not included in the packet, please click link to select appropriate panel). **For medical treatment to be paid under the claim you must seek treatment with a Panel Provider**.

PLEASE NOTE Supervisors of Auxiliary and Business Services and Office of Physical Plant employees, please complete the required Incident Investigation Form (not included in the packet, please click link to select form)

Please return signed documents via email or fax as soon as possible to:

Penn State Human Resources
Absence Management Department
The 331 Building, Suite 136
University Park, PA 16802
Fax: 814-863-6227
Email: absence@psu.edu

PLEASE NOTE: For medical treatment to be paid under the claim you must seek treatment with a Panel Provider.

COMPLETION OF THIS PAGE IS REQUIRED

Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act of a list of designated health care providers is established by the employer. (See #8 on previous page to access the panel provider information)

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the University working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any panel 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 the commonwealth is not liable for the medical bills incurred.** Specific rights and duties are:

- You have the duty to obtain treatment for work-related injuries and illnesses from one or more of the **designated health care panel providers for 90 days from the date of the first visit to a designated provider.**
- You have the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer a**s long as treatment is obtained from a designated provider during the 90-day period**.
- You have the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
- You have the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
- You have the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
- You have the right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
- You have the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.
- **You have the duty to notify the employer of treatment by a non-designated provider 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. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
- You have the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

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 they are explained above. I am aware that I must treat with a panel provider should I need medical treatment for the first 90 days, and if I do not, the University is not liable for the medical bills incurred.

_____	_____	_____
Employee's Printed Name	Employee's Signature	Date

PennState

COMPLETION OF THIS PAGE IS REQUIRED

EMPLOYEE DESCRIPTION OF INJURY FORM

Date of injury: _____ **Time:** _____ **AM/PM**

Date injury was reported: _____ **Reported to** _____

PSU ID # _____

Name of Injured Person (Please Print): _____

Address:

_____

Phone Number(s) _____ **Date of Birth:** _____ **Male** ☐ **Female** ☐

Type of Injury: _____ **Body Part(s) affected** _____

Details of injury

1. Please describe in your own words how the injury occurred. Include specific details such as equipment used, tools, etc. **(Please Print)**

_____

_____

_____

_____

_____

_____

2. Please describe where the injury occurred and what activity you were performing when the injury occurred. **(Please Print)**

_____

_____

_____

(Continue on the back of this form to add additional details.)

Witness to the injury: _____ _____

Name Contact Number

Signature of Employee _____ **Date:** _____

MAIL COMPLETED FORM PROMPTLY TO PENN STATE WORKERS' COMPENSATION, THE 331 BUILDING, SUITE 136, UNIVERSITY PARK, PA 16802.

_____

For Workers' Compensation Use Only:

Claim Number _____

COMPLETION OF THIS PAGE IS REQUIRED

WORKERS' COMPENSATION INFORMATION

To All Employees:

The Workers' Compensation law provides some replacement wages and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Employers are required to post the name of the company responsible for paying workers' compensation benefits in a prominent and easily accessible place; including areas used for the treatment of injured employees or for the administration of first aid. Penn State's Workers' Compensation coverage is provided through the Broadspire.

You should report immediately any injury or work-related illness to your supervisor or human resources representative. Your benefits could be delayed or denied if you do not notify your supervisor or human resources representative immediately.

If your claim is denied by Broadspire, then 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 No. within Pennsylvania: 800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY – 800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, pa keyword: workers' comp.

If you have questions relating to Penn State's policies and procedures relating to your work related injury, please contact Absence Management at (814) 865-1782.

For your information, a complete list of panel physicians for treatment relating to your injury is located at https://hr.psu.edu/workers-compensation/health-care-provider-panels/

For extension employees ONLY, see Penn State Extension Employee Panels - https://hr.psu.edu/workers-compensation/extension-panels/

EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYEE NAME (PRINTED): _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

COMPLETION OF THIS PAGE IS REQUIRED

Claim Number:

Broadspire
A CRAWFORD COMPANY

AUTHORIZATION TO SHARE AND USE MEDICAL INFORMATION

I allow all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information").

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Broadspire Services, Inc., their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the Information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"). I also allow the Benefits Managers to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program. I expressly waive any and all rights that I may have to be notified of these communications. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it.

I understand that this permission lasts twelve (12) months after my claim is processed or twelve (12) months after the end of my coverage under the Benefits Program, whichever is longer, unless law requires a shorter period. If I change my mind before that time, I can tell my Records Holders in writing that I do not want them to share any more information. If I tell them in writing to stop sharing information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I know I can see or copy the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original.

Claimant's Name: _____ Birth Date: _____ Date: _____

_____ _____

Claimant's Signature Witness Name and Relationship

Employer's Name: Penn State University

NOTICE TO RECORDS HOLDERS

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.

THIS PAGE IS FOR THE EMPLOYEE TO KEEP

KEYSCRIPTS

PennState

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: THE PENNSYLVANIA STATE UNIVERSITY

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: **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, Walmart, as well as University Health Services (University Park). **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: PSU10030

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

COMPLETION OF THIS PAGE IS REQUIRED

Penn State University Workers' Compensation Selection of 3 for 1

PLEASE NOTE: <u>All employees must use their own paid time off for all appointments, treatments, and testing related to their On the Job Injury (OJI).</u> _____ **INITIAL HERE**

<u>Eligibility:</u> Employee with an on the job injury/illness (OJI) compensable (covered) under the Workers' Compensation Act, Occupational Disease Act, or similar legislation.

<u>Eligible Employees:</u>

- Bargaining Unit Employees hired prior 7/1/2014
- Staff employees
- PSUPOA employees hired prior to 4/1/2019

<u>Contact Information:</u>

First Name:_____
Last Name:_____
Hire Date:_____
PSU ID Number:_____
Phone Number:_____
PSU E-mail:_____

Please select one of the following:

Please note: Using the 3 for 1 benefit will charge EACH OJI related absence at your full working hours per day. On the last working day of the month your balance(s) will be adjusted to reflect the appropriate 2/3 credit for all OJI time used.

If you have questions about using the 3 for 1 benefit, please contact Absence Management PRIOR to completing this page.

◯ I, _____, elect to receive my full Penn State University salary and to be charged 1/3 of a day of **accumulated sick leave**. I authorize Penn State University to deposit compensation checks to the account information listed on the attached LIBC-10 form. I understand that if my sick time is exhausted prior to the end of the month, I will be placed on an OJI unpaid leave and the OJI credit will remain in my balances until I return.

◯ I, _____, elect to receive my full Penn State University salary and to be charged 1/3 of a day of **accumulated sick leave, accumulated vacation, and other earned time** if sick leave is exhausted during my absence. I authorize Penn State University to deposit compensation checks to the account information listed on the attached LIBC-10 form. I understand that if my sick time is exhausted prior to receiving the end of the month OJI credit, that my other earned time will be used to complete the current month.

◯ I, _____, elect not to participate in 3 for 1 and/or I am not an eligible employee. I am aware that I need to use my OWN time for all absences.

Employee Signature: _____ Date: _____

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AUTHORIZATION FOR ALTERNATIVE DELIVERY OF COMPENSATION PAYMENTS

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER: X X X - X X - _____ _____ DATE OF INJURY: MM DD YYYY WCAIS CLAIM NUMBER

EMPLOYEE

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____

EMPLOYER

Name The Pennsylvania State University
Address The 331 Building
Address Suite 234
City/Town University Park State PA ZIP 16802
County Centre
Telephone 814-865-1782 FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name Broadspire
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
Contact _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

DATE OF AUTHORIZATION
MM DD YYYY

I, _____ , hereby authorize and agree that the checks for the compensation payments due
Claimant name (please print)
to me shall be forwarded to me in the following designated manner:

☐ I will pick up my checks at (please check only one box): ☐ employer office ☐ insurer office

☐ The employer/insurer will mail my checks to me at:

_____
_____

☐ The employer/insurer will direct deposit my checks to the account at the financial institution supplied on the attached authorization for direct deposit. (Attach authorization for direct deposit provided by your financial institution.)

☒ Other:

Direct Deposit via ACH to RBS Citizens % The Penn State University
_____
_____

I understand that my employer/insurer is required to mail my compensation checks to my last known address and that I am not under any obligation to authorize the method of delivery outlined above.

Claimant's signature

Claimant's name (typed/printed)

Employer/Insurer representative's signature

Employer/Insurer representative's name (typed/printed)

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program