

**\*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> (**must use Internet Explorer**)  
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. KEYSERITS 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.**

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

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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

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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 **as 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.**

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Employee's Printed Name

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Employee's Signature

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Date



**PennState**

## 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)

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

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(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 \_\_\_\_\_  
An Equal Opportunity University  
OHR 4/2019

## **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 Sedgwick.

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 Sedgwick, 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](http://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: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

I authorize each of the parties identified below to use and disclose any and all of my individually identifiable medical or health information, as described below, for purposes of administering my claim. I understand that the information about me that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations.

I specifically authorize physicians, nurses and hospitals to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of such communications, and I hereby authorize Sedgwick Claims Management Services, Inc., my employer and their representatives and agents ("Sedgwick CMS") to initiate and conduct such communications whether or not I am present or have received notice thereof.

1. What Information is covered by this Authorization? This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing health or medical conditions or illnesses (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to my workers compensation claim.
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My information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care providers. If directly related to my claimed condition or illness, this information may include the following. Please check yes or no and initial:

HIV test results, HIV or AIDS information.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____
Psychiatric information.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____
Information related to drug or alcohol abuse.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____

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.

2. Who may disclose and receive Information under this Authorization?

- A. I authorize Sedgwick, my Employer, and their representatives and agents to communicate directly both orally and in writing with all treating physicians or medical providers of any kind regarding all facts and opinions relevant to my workers' compensation claim. I authorize any treating physician or other medical provider to communicate directly both orally and in writing with Sedgwick, my Employer, and their representatives and agents, concerning all aspects of my treatment for the illness or injury for which I am receiving or seeking benefits.
- B. When relevant to my claim, Sedgwick CMS may re-disclose (without my further authorization) any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors and service providers that may receive any such information from my employer to the extent permitted by state or federal law; or (d) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick CMS may use my information obtained pursuant to this authorization in any other claim matter that Sedgwick CMS may administer or handle related to me.

3. How Long this Authorization is Valid? This authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under applicable federal or state law.

4. Revocation of this Authorization. Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying, in writing, Sedgwick CMS of my revocation and that my revocation shall be effective upon Sedgwick CMS' receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick CMS before it receives my revocation.
5. Processing of Claims. I understand that this Authorization is generally necessary for the processing of my Workers' Compensation claim. Failure to sign this Authorization may impair or impede the processing of my claim.
6. Refusal To Sign. I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Printed Name of Patient or Patient's Representative

\_\_\_\_\_  
Representative's Relationship to Patient, if applicable

\_\_\_\_\_  
First Day Absent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Sedgwick CMS 01/01/2011

\_\_\_\_\_  
©Sedgwick Claims Management Services, Inc.

#### NOTICE OF STATE FRAUD REQUIREMENTS

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.



**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.*



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**

## Penn State University Workers' Compensation Selection of 3 for 1

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

### Eligible Employees:

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

### Contact Information:

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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## AUTHORIZATION FOR ALTERNATIVE DELIVERY OF COMPENSATION PAYMENTS

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

XXX - XX -

WC ID NUMBER

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 Sedgwick  
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.

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Claimant's signature

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Claimant's name (typed/printed)

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Employer/Insurer representative's signature

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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**  
toll-free inside PA TTY: 800.362.4228  
local & outside PA TTY: 717.772.4991

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



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