Please have the employee complete this Workers’ Compensation Signature Packet in addition to submission of an injury report using:

Online system link located at – [http://ohr.psu.edu/workers-compensation/](http://ohr.psu.edu/workers-compensation/)

or

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. TMESYS 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)*
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)

*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 to:**

Office of Human Resources  
Absence Management Team  
405 James M. Elliott Building  
University Park, PA 16802  
Fax: 814-863-6227  
Email: absence@psu.edu
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 [your campus] http://ohr.psu.edu/workers-compensation/ for you to view. Also, you may get a copy of this list from [insert contact information].

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 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: ____________________________

(OVER)
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 (CCOs).

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.

BUREAU OF WORKERS’ COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
(717) 772-4447 (local and calls outside PA)
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, 410 JAMES M. ELLIOTT BUILDING, UNIVERSITY PARK, PA 16802.

For Workers’ Compensation Use Only:

Claim Number ____________________________________________

An Equal Opportunity University
OHR 3/10
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, pa keyword: workers’ comp.

In addition you can contact your human resources representative or the University’s Workers’ Compensation Office (814-865-0424) if you have any questions about Penn State’s policies.

Also attached to this sheet is a complete list of panel physicians and medical providers for your reference.

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.

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 ☐ NO ☐ Initial here __________
- Psychiatric information. YES ☐ NO ☐ Initial here __________
- Information related to drug or alcohol abuse. YES ☐ NO ☐ 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.

<table>
<thead>
<tr>
<th>Signature of Patient or Patient’s Representative</th>
<th>Patient’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name of Patient or Patient’s Representative</td>
<td>First Day Absent</td>
</tr>
<tr>
<td>Representative’s Relationship to Patient, if applicable</td>
<td>Date Signed</td>
</tr>
<tr>
<td></td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
<td>Witness</td>
</tr>
</tbody>
</table>

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.
MAKING IT EASY...
TO GET WORKERS’ COMPENSATION PRESCRIPTIONS FILLED.

Helios has been chosen to manage your workers’ compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:
If you need a prescription filled for a work-related injury or illness, go to a Helios Tmesys network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers’ compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 866.599.5426 or visit www.tmesys.com and click on “Pharmacy Locator.”

Questions? Need Help?
866.599.5426

NOTE: This First Fill card is only valid for your workers’ compensation injury or illness.

Employer:
Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.
Penn State University Workers' Compensation
Selection of 3 for 1

Eligibility: Employee with an injury or illness 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

Contact Information:
Claim #:____________________________________________________________
First Name:_________________________________________________________
Last Name:_________________________________________________________
Hire Date:__________________________________________________________
PSU ID Number:_____________________________________________________
Phone Number:_____________________________________________________
PSU E-mail:_________________________________________________________

Please select one of the following:

☐ 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, ________________, 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, ________________, 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

EMPLOYEE
First name ____________________________
Last name ____________________________
Date of birth __________________________
Address ______________________________
Address ______________________________
City/Town _____________________________ State ______ ZIP ______
County _______________________________
Telephone ____________________________

DATE OF AUTHORIZATION

EMPLOYER
Name _________________________________
Address ______________________________
Address ______________________________
City/Town _____________________________ State ______ ZIP ______
County _______________________________
Telephone ____________________________
FEIN ______

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)
Name _________________________________
Address ______________________________
Address ______________________________
City/Town _____________________________ State ______ ZIP ______
County _______________________________
Telephone ____________________________
FEIN ______
Contact ______________________________
NAIC code ____________________________ or Insurer code ____________
Insurer/TPA claim # ____________________

Claimant name (please print) _________________________________, hereby authorize and agree that the checks for the compensation payments due 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).