General McLane School District - Edinboro (16412)
(7/18/2024)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.

2. In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers:

3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.

4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.

6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.

7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

PLEASE CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-855-572-3926 FOR ASSISTANCE IN SCHEDULING PHYSICAL/OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITIATION OR SEND THE REFERRAL FORM TO easternreferrals@medrisknet.com

Name	Address	Scheduling	Area of Specialty
Concentra Medical Centers	3010 W Lake Rd Erie, PA 16505	814-833-2385	Occupational Medicine
Workplace Health	11277 Vernon Place Suite 101 Meadville, 16335	814-333-5503	Occupational Medicine
The Occupational Health Center	2501 W 12th St Ste C Erie, PA 16505	814-452-7879	Occupational Medicine
MedExpress Urgent Care	5039 Peach St Erie, PA 16509	814-866-1443	Urgent Care
UPMC Urgent Care	7200 Peach Street Erie, PA 16509	814-877-4110	Urgent Care
Ahn Express Care	4247 W Ridge Rd Ste 101 Erie, PA 16506	814-835-2580	Urgent Care
Orthopedic & Sports Medicine of Erie - UPMC	100 Peach Street Ste 400 Erie, PA 16507	814-454-8287	Orthopedics
Orthopedic Associates of Meadville David J Carl	11277 Vernon Pl Ste 200 Meadville, PA 16335	814-724-1252	Orthopedics
Contemporary Ophthalmology of Erie	2640 Zuck Rd Erie, PA 16506	814-838-9555	Ophthalmology
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Pharmacy
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Durable Medical Equipment
MedRisk	Call Toll Free for Scheduling	1-855-572-3926	Physical and Occupational Therapy Chiropractic Care
One Call Care Management	Call Toll Free for Closest Location	1-866-695-3265	MRI

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Workers' Compensation is designed to provide wage loss benefits and payment for reasonable medical care for one who is injured on the job.

Remember: It is important to tell your employer about your injury immediately.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you must select. You must obtain treatment from one or more of these providers for ninety (90) days from the date of your first visit.

If you have a medical emergency, you may go to the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you seek treatment from a non-panel provider within the first ninety (90) days following your first visit, your employer will not have to pay for those services.

In the event invasive surgery is prescribed by a physician or other health care provider on your employer's panel, you are entitled to a second opinion from any other health care provider of your choice. If the opinion differs from the one provided by the panel provider, you may choose which course of treatment to follow. However, the second opinion must state a specific course of treatment. If you choose the treatment offered by the second opinion you must receive that treatment from a panel provider for a period of ninety (90) days from the date of the visit to the provider of the second opinion.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of services rendered if such services are determined to have been unreasonable or unnecessary. The non-panel provider must provide an initial report to the employer, within ten (10) days of the first treatment and every thirty (30) days thereafter, as long as the treatment continues.

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.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

At Time of Hire ***After an Injury***

Employee Signature_____ Date_____

Witness Signature_____ Date_____

Eastern Alliance Insurance Group
Claim Reporting Worksheet

Injury Information

Date of injury: _____ Time of Injury:_____

Injured Worker-Personal Information

Injured Worker's name: _____

Birth date: ____/____/_____ [l·ăű n 2Ŧ Social Security Number: _____ Gender:_____

Injured Worker's mailing address: _____

Job Title:_____

Employee Status (Full-time/Part-time):_____

Injured Worker's phone #: (____) _____ Email:_____

Days Worked Per Week:_____ Hours Worked Per Day:_____

Location (building) where injury occurred:_____

Department:_____

Accident Information

Date employer first notified of injury: ____/_____/_____

Nature of injury:_____

Cause of injury:_____

Body part(s) injured:_____

Accident/injury description: _____

_____

_____

_____

_____

Witness Name(s):_____

Supervisor Name & Phone Number:_____

Treatment Information

Provider:_____

Provider Address:_____

Provider Phone:_____