LACKAWANNA INSURANCE GROUP

Pennsylvania Claims Kit

Contact Information

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www.Ligins.com

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Introduction

Each state has a dedicated claims kit to describe the full procedure an insured goes through with Lackawanna Insurance Group. Pre-Injury Forms are the necessary forms an employee must complete after starting employment. Report a Claim contains all the steps needed to report the claim in case an injury occurs. Cost Containment is for maintaining the expenses of the reported claim.

Pre-Injury

- The Workers' Compensation Employee Notification and the Workers' Compensation Information Forms are to be initially signed by the employee and then kept by the company incase an injury occurs.
- The LIBC 500 is an employee notice that is to be posted in the workplace.

Report an Injury

- Complete the First Report of Injury form and submit to the claims office within 48 hrs. for a fatality and 7 days for all other injuries (see Claims Reporting Procedures).
- Have the employee re-sign the Workers' Compensation Information form. Forward a copy to the claims office.
- Have the employee re-sign the Workers' Compensation Notification form. Forward a copy to the claims office.
- Have the employee sign an Authorization form. Forward it to the claims office.
- Determine OSHA Reporting Eligibility

Cost Containment

- Provider Panel Program with Appointment Scheduling Services
- Pharmacy Program
- Return to Work Program

Pre-Injury

Pre-Injury Procedure

1. The Workers' Compensation Employee Notification and the Workers' Compensation Information Forms are to be initially signed by the employee and then kept by the company incase an injury occurs.
2. The LIBC 500 is an employee notice that is to be posted in the workplace.

WORKERS' COMPENSATION INFORMATION

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) 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 number within Pennsylvania (800) 482-2383; telephone number 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.

EMPLOYEE INITIAL ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**

EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION AT OR SOON AFTER THE TIME OF CLAIMED WORK INJURY
I HEREBY ACKNOWLEDGE THAT I HAVE AGAIN RECEIVED AND RE-READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**

INFORMACIÓN DE LA REMUNERACIÓN DE LOS TRABAJADORES

(1) El workers' la ley de la remuneración proporciona pérdida del salario y ventajas médicas a los empleados que no pueden trabajar, o que necesitan asistencia médica, debido a lesión relacionada con el trabajo.

(2) Las ventajas se requieren para ser pagadas por su patrón cuando los uno mismo-asegurados, o con el seguro proporcionado por su patrón. Requieren a su patrón fijar el nombre de la compañía responsable de pagar workers' ventajas de la remuneración en su lugar del negocio primario y en sus sitios del empleo en un lugar prominente y fácilmente accesible, incluyendo, sin la limitación, las áreas usadas para el tratamiento de empleados dañados o para la administración de los primeros auxilios.

(3) Usted debe divulgar inmediatamente cualquier lesión o enfermedad relacionada con el trabajo a su patrón.

(4) Sus ventajas podrían ser retrasadas o ser negadas si usted no notifica a su patrón inmediatamente.

(5) Si su demanda es negada por su patrón, usted tiene la derecha de solicitar una audiencia antes de un workers' juez de la remuneración.

(6) La oficina de Workers' La remuneración no puede proporcionar asesoramiento jurídico. Sin embargo, usted puede entrar en contacto con la oficina de Workers' Remuneración para la información de carácter general adicional en: Oficina de Workers' Remuneración, calle del sur de 1171 Cameron, sitio 103, Harrisburg, Pennsylvania 17104-2501; número de teléfono dentro de Pennsylvania (800) 482-2383; número de teléfono fuera de la esta Commonwealth (717) 772-4447; Equipo teleescritor (800) 362-4228 (para la audiencia y el discurso deteriorados solamente); www.state.pa.us, palabra clave del PA: compartimiento de los trabajadores.

ACUSE INICIAL DEL EMPLEADO DE RECIBO DE WORKERS' INFORMACIÓN DE LA REMUNERACIÓN

RECONOZCO POR ESTE MEDIO QUE HE RECIBIDO Y LEÍ EL WORKERS' LA INFORMACIÓN DE LA REMUNERACIÓN PROPORCIONÓ ADJUNTO.

_____ _____

Nombre del empleado Firma del empleado Fecha

ACUSE DE EMPLYEE DE RECIBO DE WORKERS' INFORMACIÓN DE LA REMUNERACIÓN EN O PRONTO DESPUÉS DE LA ÉPOCA DE LA LESIÓN DE TRABAJO DEMANDADA

RECONOZCO POR ESTE MEDIO QUE HE RECIBIDO Y RELEÍA OTRA VEZ EL WORKERS' LA INFORMACIÓN DE LA REMUNERACIÓN PROPORCIONÓ ADJUNTO.

_____ _____

Nombre del empleado Firma del empleado Fecha

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her 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. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

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 your employer will pay for that treatment.

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 the treatment rendered by the provider to 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. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the 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 non-designated health care provider and only if that notice is provided to your employer within five (5) days of 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 a designated health care provider prescribe invasive surgery, 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 PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

_____	_____	_____
Employee Name	**Employee Signature**	**Date**

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

_____	_____	_____
Employee Name	**Employee Signature**	**Date**

NOTIFICACIÓN AL EMPLEADO DEL SISTEMA DE INDEMNIZACIÓN AL TRABAJADOR

El uso del género masculino en este documento implica tanto el género masculino como el género femenino.

El Decreto del Estado de Pennsylvania de la Indemnización al Trabajador esta diseñado para proveer cuidados médicos razonables, a quien sufre una lesión que ocurre en el transcurso de su empleo y cuya causa esta relacionada a ello. De acuerdo al Decreto, su empleador proporcionará el pago por servicios médicos y quirúrgicos razonables, por servicios suministrados por médicos y otros proveedores del cuidado de la salud, por medicinas y por suministros que son necesarios y cuando sean necesarios.

Si usted requiere tratamiento médico de emergencia, usted puede conseguirlo con cualquier proveedor médico, sin embargo, cualquier otro tratamiento subsiguiente que no sea de emergencia, tiene que ser obtenido y suministrado por uno de los designados proveedores del cuidado de la salud cuyos nombres aparecen en la lista de anuncio presentada en los establecimientos de su empleador. Si usted se encuentra con una emergencia médica, usted puede obtener asistencia o ayuda de parte de un hospital o médico de su elección. Sin embargo, una vez que la emergencia ya no existe, el empleado lesionado tiene que ser tratado por uno de los proveedores nombrados en la lista, por el resto del período de noventa (90) días.

Durante los primeros noventa (90) días a partir de la fecha de su primera visita, usted puede y tiene el derecho de cambiar el proveedor por otro en la lista, y su empleador pagará por ese tratamiento o cita.

Si un proveedor designado del cuidado de la salud, lo manda o recomienda a usted para ser tratado por otro proveedor del cuidado de la salud cuyo nombre no está en la lista, su empleador pagará por el tratamiento suministrado por el proveedor al cual usted fue mandado o recomendado.

Naturalmente, usted tiene el derecho de conseguir tratamiento o consulta médica de parte de un proveedor del cuidado de la salud, el cual no es uno de los designados en la lista, durante los primeros noventa (90) días a partir de la primera visita, pero entonces usted es la persona responsable por el pago de esos servicios.

Usted tiene el derecho de conseguir tratamiento de parte de cualquier proveedor del cuidado de la salud, una vez terminado el período de noventa (90) días a partir de la primera visita. Su empleador pagará por ese tratamiento a menos que dicho tratamiento sea evaluado como innecesario o irrazonable por una organización de reevaluación de utilización de acuerdo al proceso de reevaluación de utilización contenido en el Decreto de Indemnización al Trabajador.

Su empleador será responsable por el costo de ese tratamiento después de que el período inicial de noventa (90) días ha terminado pero, solamente si usted notifica a su empleador, que usted esta recibiendo tratamiento de parte de un proveedor del cuidado de la salud el cual no es uno de los designados en la lista, y solo si esa notificación es dada a su empleador dentro de cinco (5) días a partir de la primera visita a ese proveedor. Si usted proporciona la notificación a su empleador acerca del tratamiento por un proveedor del cuidado de la salud el cual no es uno de los designados en la lista, más allá de cinco (5) días después de la primera visita a ese proveedor, el empleador no será responsable por el pago del tratamiento suministrado por ese proveedor no-designado en la lista, hasta que no reciba notificación de su parte de que usted está recibiendo dicho tratamiento.

En caso de que un designado proveedor del cuidado de la salud, prescribiera, recetara o recomendara cirugía de procedimiento invasivo, su empleador pagará por una opinión adicional de parte de un proveedor del cuidado de la salud de su elección. Si esta opinión adicional no concuerda con la opinión del designado proveedor del cuidado de la salud, y si la opinión adicional proporciona un detallado y específico curso de tratamiento, usted determinará que curso de tratamiento a seguir. Si usted elige seguir el tratamiento recomendado en la opinión adicional, su empleador pagará para que dichos procedimientos sean suministrados por uno de sus designados proveedores del cuidado de la salud y no será responsable por el pago de tratamientos suministrados por proveedores no-designados por un período de noventa (90) días a partir de la fecha de su visita al proveedor que proporcionó la opinión adicional.

YO POR LA PRESENTE RECONOZCO QUE HE SIDO INFORMADO DE Y QUE ENTIENDO MIS DERECHOS Y DEBERES BAJO EL DECRETO DE LA INDEMNIZACIÓN DEL TRABAJADOR COMO HAN SIDO PRESENTADOS AQUÍ.

_____	_____	_____
Nombre del Empleado	Firma del Empleado	Fecha

RE-NOTIFICACIÓN AL EMPLEADO EN EL O CERCA DEL MOMENTO DE LA RECLAMADA LESIÓN EN EL TRABAJO

Yo por la presente reconozco que he sido informado de nuevo y que entiendo mis derechos y deberes bajo el Decreto de la Indemnización del Trabajador de Pennsylvania. Yo he recibido una copia de este formulario de notificación de la Indemnización al Trabajador.

_____	_____	_____
Nombre del Empleado	Firma del Empleado	Fecha

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:

Address:

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number: _____

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

Report a Claim

Report a Claim Procedure

1. Complete the First Report of Injury form and submit to the claims office within 48 hrs. for a fatality and 7 days for all other injuries (see Claims Reporting Procedures).
2. Have the employee re-sign the Workers' Compensation Information form. Forward a copy to the claims office.
3. Have the employee re-sign the Workers' Compensation Notification form. Forward a copy to the claims office.
4. Have the employee sign an Authorization form. Forward it to the claims office.
5. Determine OSHA Reporting Eligibility

Lackawanna Insurance Group
First Notice of Loss Reporting Procedures

The Pennsylvania Bureau of Workers' Compensation only accepts electronic injury reports from Insurers and requires submission of an injury report within 48 hours for injuries resulting in death and within 7 days for all other injuries.

For Lackawanna Insurance Group to timely report injuries to the Pennsylvania Bureau of Workers' Compensation the Insured must immediately after an injury complete and submit our First Report of Injury Form. It is necessary to complete at least the required fields on our First Report of Injury Form since this information is required by the Pennsylvania Bureau of Workers' Compensation.

Lackawanna provides the options to submit your First report of injury online or by paper

On-Line Reporting:

1. Log onto LIGINS.com
2. Click on Report a Claim Online Filing
3. Complete the On-Line First Report of Injury Form
4. Click on Print and maintain a copy for your records
5. Click on Acknowledge & SUBMIT
6. Receive a confirmation that your on-line First Report of Injury was successful

Paper Reporting:

1. Complete the First Report of Injury form located on pages 10 & 11
2. **Fax completed form to:** 570-824-7969
   Or
   Mail completed form to: Lackawanna Insurance Group
   PO Box 270
   Wilkes Barre, PA 18703

Lackawanna Insurance Group
Workers' Compensation
First Report of Injury Form

Page 1 of 2

(* denotes required field)

***Date of Injury:**			
***Employee Social Security No:**			
***Employee First Name:**	***Employee Last Name:**		
***Street Address:**			
***City:**	***State:**	***Zip Code:**	
County:	***Phone No:**		
***Date of Birth:**	***Gender:**	**Marital Status:**	**No. of Dependents:**
***Occupation or Job Title:**	***Employment Status:**	***Date of Hire:**	
***Employer:**			
***Employer Contact First Name:**	***Employer Contact Last Name:**		
***Employer Contact Phone No:**	**Employer Contact Fax No:**	**Employer Contact E-Mail Address:**	
***Street Address:**			
***City:**	***State:**	***Zip Code:**	
County:	***Phone No:**		
Employer FEIN.:	**Policy Number:**	**Policy Period Dates:**	
***Date & Time Employer Notified:**	***Time employee began work:**	***Time of occurrence:**	
***Full pay for day of injury?:**	**Last day worked:**	**Date of disability:**	**Date returned to work:**

*Type of Injury:	*Part of Body Affected:	*Cause of Injury:

*How injury/illness/abnormal health condition occurred. Describe sequence of events including objects/substances directly responsible:

*Did injury or illness occur on employer's premises?:	*If accident did not occur at Employer Address provided on page one (1), please provide complete address:	*If Injury Out of State, Specify State:

*Were safeguards or safety equipment provided?:	*Were safeguards or safety equipment used?:

All equipment, material, or chemicals employee was using when accident or illness exposure started:

If fatal, give date of death:

Type of Initial Treatment:

- ☐ No (formal) Medical Treatment; only first aid
- ☐ Hospital – Emergency Care
- ☐ Panel Physician
- ☐ Employee Physician

Healthcare Provider Name:

Street Address:

City:	State:	Zip Code:

Phone No:

Witness First Name:	Witness Last Name:

Witness Phone No.:

*Person Completing This Form – Name:	*Phone Number:

Claim Forms

In addition to submitting the First Report of Injury Form, please have the employee sign the Authorization to Release. Then have the employee re-sign, their Workers' Compensation Employee Notification and Workers' Compensation Information forms that they signed previously before the injury occurred.

Fax completed forms to: (570) 824-7969

OR

Mail completed forms to: Lackawanna Insurance
Group PO Box 270
Wilkes Barre, PA 18703.

Authorization to Release Information

To Whom It May Concern:

I hereby request and authorize you to furnish to Lackawanna Insurance Group any and all information you have concerning

_____,

with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records and / or other Workers' Compensation records.

I further request and authorize employers to furnish complete information including but not limited to wages, commissions, and any other form of compensation.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

Date: _____

Signature: _____

Print Name: _____

Street Address:

_____

City: _____ State: _____ Zip: _____

Lackawanna Insurance Group

Lackawanna Casualty Company • Lackawanna American Insurance Company • Lackawanna National Insurance Company

Autorización a la información de lanzamiento

A quien pueda interesar:

Le solicito y autorizo por este medio suministrar al grupo del seguro de Lackawanna y toda la información que usted tiene referente a _____, con respecto a cualquier enfermedad o lesión, historial médico, consultas, tratamiento, incluyendo radiografías, así como las copias de todo el hospital o informes médicos, los expedientes de los militares y/o el otro Workers' Expedientes de la remuneración.

Solicito y autorizo más lejos a patrones suministrar la información completa que incluye pero no limitada a los salarios, a las comisiones, y a cualquier otra forma de remuneración.

Una fotocopia de esta autorización será considerada como eficaz y válido como la autorización del orgional.

Fecha:_____ Firma:_____

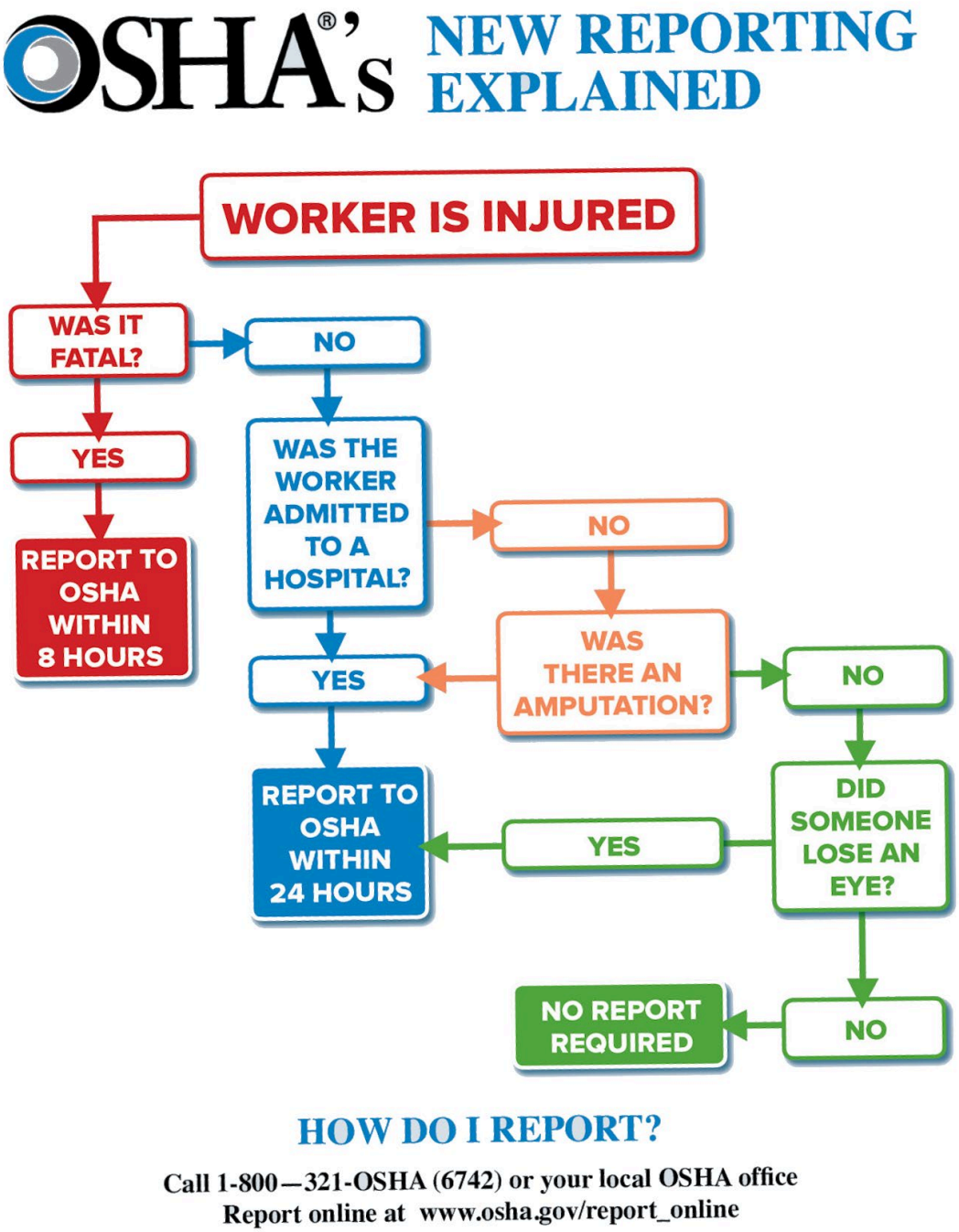
Nombre de la impresión: _____

Dirección de calle:_____

Ciudad:_____Estado:_____Cierre relámpago: _____

Determine OSHA Reporting Eligibility

Employers are required to notify OSHA when an employee is killed on the job or suffers a work-related hospitalization, amputation, or loss of an eye. A fatality must be reported within 8 hours and in-patient hospitalization, amputation, or eye loss must be reported within 24 hours. If your incident matches the reporting criteria please proceed to OSHA's Website to notify OSHA.



Cost Containment

Cost Containment Procedure

1. Provider Panel Program with Appointment Scheduling Services
2. Pharmacy Program
3. Return to Work Program

Provider Panel Program with Appointment Scheduling Services

Lackawanna Insurance Group is pleased to provide the services of Premier Comp Solutions to our policyholder in developing a functional provider panel that will meet the policyholder's specific needs. Premier Comp selects licensed healthcare providers for placement on panels based on the following criteria:

- Client Preference
- Specialties appropriate for the anticipated work injuries.
- Quality of care and reputation in their field of specialty.
- Timeliness of consultations, evaluations, and follow up appointments.
- Willingness to address return-to-work status and modified duty.
- Ability to provide timely written medical reports

Additionally, if Premier Comp Solutions creates a provider panel for a policyholder, as added value, it offers 24/7 Toll Free Appointment Scheduling. Furthermore, this allows access to discounted physical therapy/diagnostic services networks. Access to these networks can significantly reduce the costs associated with physical therapy and diagnostic studies.
Premier Comp Phone: 412-494-4001
Premier Comp Fax: 412-494-4002

Pharmacy Program

Lackawanna Insurance Group's managed care pharmacy program, along with our pharmacy benefits manager Optum, offers the First Fill Program which is committed to helping injured workers recover and return to work.

Benefits for Employers

- First Fill immediately directs injured workers to our pharmacy network manager for better drug utilization management.
- The program helps ensure injured workers receive the most appropriate medication for their injury at the right time.
- This efficient and effective process assists in controlling prescription medication costs.

Benefits for Employees

- All eligible employees injured on the job are automatically enrolled in the First Fill program.
- The employer provides a First Fill card to the injured worker when he or she seeks initial medical treatment. The employee has no out-of-pocket expenses.
- Employees may use the First Fill card at all major pharmacy chains, nearly 70,000 pharmacy locations.

Program Limitations

- The card expires at midnight on the day the pharmacy fills the prescription.
- After the card expires, all eligible injured workers will be automatically enrolled in the Optum retail drug card program to obtain pharmacy services related to their workers compensation claim.
- There is a limit of $300 per medication.
- First Fill-covered medications are limited to those selected drug classes used to treat common workplace injuries (e.g., anti-inflammatories, antibiotics, muscle relaxants).

Optum Customer Service: 1-800-356-3477

Return to Work Program

Employers are encouraged to establish a transitional program whereby employees continue to work during their healing and recovery period. It has been recognized that employees that continue to work with limitations/restrictions have a quicker recovery rate and a better outcome, as opposed to an employee who remains out of work and receives disability wage loss benefits.
By providing transitional duty to an injured employee an employer can reduce workers' compensation costs, avoid costs of hiring and training a replacement worker, reduce fraud, and promote employee morale.