LACKAWANNA INSURANCE GROUP

Pennsylvania Claims Kit

46 Public Square, Suite 501
P.O. Box 270 Wilkes-Barre, PA 18701
Phone: (570) 824-1400 or (888) 280-5225
Fax: (570) 824-7969
www.ligins.com

Table of Contents

1. Guidelines .....
2. Pre-Injury .....
    2.1. LIBC 500 .....
    2.2. Workers' Compensation Information Form .....
    2.3. Workers' Compensation Employee Notification Form .....
3. Report an Injury .....
    3.1. First Report of Injury Form .....
    3.2. Post Injury Forms .....
    3.3. Determine OSHA Reporting Eligibility .....
4. Cost Containment .....

Guidelines

Pre-Injury

1. The LIBC 500 is an employer notice that is to be posted in the workplace.
2. Obtain the employee signature on the Workers Compensation Information form (re-sign at time of injury).
3. Obtain the employee signature on the Workers Compensation Employee Notification form (re-sign at time of injury).

Report an Injury

1. Submit the First Report of injury immediately (Fatalities must be reported within 8 hours).
   Online First Report of Injury submission: **(Recommended Method)**
   - Log into ligins.com
   - Click “Report a Claim” Button
   - Complete the online First Report of Injury form
   - Click “Acknowledge & Submit”
   - A claim number will be generated immediately

   Paper First Report of Injury submission:
   - Complete the paper First Report of Injury form
   - Fax the completed form to: (570) 824-7969 **OR**
     Mail to: 46 Public Square, Suite 501 Wilkes-Barre, PA 18701
2. Obtain the employee’s signature on the Authorization to Release Information form. Re-sign the Workers Compensation Employee Notification and Information forms
3. Determine OSHA Reporting Eligibility

Cost Containment

1. Review our cost containment measures that may assist you in mitigating claims cost while providing quality care to the injured employee.

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

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

Lackawanna Insurance Group

Lackawanna Casualty Company, Lackawanna American Insurance Company, Lackawanna National Insurance Company

46 Public Square, Suite 501
PO Box 270
Wilkes Barre, PA 18703
(570) 824-1400
(888) 280-5225
(570) 824-7969 (fax)
www.ligins.com

Workers Compensation First Report of Injury (FROI)

Please complete **at least** the shaded fields

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (Month Date Year)

TIME OF INJURY

STATE OF INJURY

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

GENDER

DATE OF BIRTH (Month Date Year)

MARITAL STATUS

OCCUPATION OR JOB TITLE

DATE OF HIRE (Month Date Year)

EMPLOYMENT STATUS

FT=Full-time
PT = Part-Time
SLFT = Seasonal Full-time
SLPT = Seasonal Part-time
VO = Volunteer
OTH: Other

EMPLOYER

STREET ADDRESS

CITY

STATE

ZIP CODE

EMPLOYER FEDERAL ID NO:

POLICY NUMBER

POLICY PERIOD

EMPLOYER CONTACT NAME

PHONE NUMBER

FAX NUMBER

E-MAIL ADDRESS

DID INJURY/ILLNESS OCCUR AT ABOVE LISTED EMPLOYER'S ADDRESS? IF NO, COMPLETE ADDRESS WHERE INJURY/ILLNESS OCCURRED,

DATE EMPLOYER NOTIFIED

Month Date Year

TIME EMPLOYEE BEGAN WORK

FULL PAY FOR DAYOF INJURY?

IS EMPLOYEE OUT OF WORK DUE TO INJURY?

LAST DAY WORKED

Month Date Year

DATE DISABILITY BEGAN (1st Day Out of Work)

Month Date Year

DATE RETURNED TO WORK

Month Date Year

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?

WERE SAFEGUARDS OR SAFETYEQUIPMENT USED?

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY/ ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH

Month Date Year

WITNESS NAME

WITNESS PHONE NO

TREATMENT:

	NO MEDICAL TREATMENT SOUGHT
	PANEL PROVIDER
	EMPLOYEE PHYSICIAN
	EMEGENCY - HOSPITAL
	HOSPITILIZATION – MORE THAN 24 HOURS

HEALTHCARE PROVIDER NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

FAX NUMBER

INITIAL TREATMENT DATE

Month Date Year

NAME OF PERSON COMPLETING FORM

PHONE NUMBER

AUTHORIZATION TO RELEASE, USE AND DISCLOSE PROTECTED INFORMATION
45 CFR 164.508 & 164.512 (HIPAA)

NAME: DATE OF BIRTH:

ADDRESS: SS#:

CLAIM #:

I authorize the disclosure and release of any and all protected health information including but not limited to: WRITTEN MEDICAL RECORDS: any and all medical records, all in patient and outpatient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory records and diagnostic reports. PRESCRIPTION RECORDS: any and all prescription records, original doctor's prescription forms, refill records and pharmacy records. BILLING: any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports. EMPLOYMENT RECORDS: any and all employment records including wage information and personnel documents. BUREAU RECORDS: any and all Bureau of Workers' Compensation records for any and all workers' compensation claims. INSURANCE RECORDS: any and all documents regarding any insurance claim involving a physical injury including, but not limited to, all medical records, correspondence, medical history, police reports, payment ledgers and all other documents contained in the claim(s) file This authorization applies to all medical records, injuries, medical history, employment and physical condition regardless of the time of occurrence both prior to and subsequent to my signature on this form regardless of time of occurrence.

HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not Release: _____ HIV _____ Mental Health _____ Drug & Alcohol

This protected health information is disclosed for the following purpose: **Workers' Compensation Claim**

This information will be used for the purpose of verifying, evaluating and/or negotiating the individual's claim. This information is not required for obtaining treatment.

You are authorized to release the above records to the following: Lackawanna Insurance Group and its agent(s) for the purpose of medical record procurement.

I have the right to revoke this Authorization, in writing, by sending written notification to the covered entity. I understand that my decision to revoke the authorization may result in a denial of my workers' compensation claim for failure to comply with a medical record request, but it will not affect my ability to obtain treatment from any covered entity. I further understand that a revocation is not effective to the extent that you have relied upon my authorization to disclose protected health information prior to revocation. In addition, I understand that the information may be re-disclosed and no longer subject to protection. I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed.
- Refuse to sign this authorization, subject to any possible sanctions imposed by the Pennsylvania Workers' Compensation Act and its Regulations.
- That I am entitled to a copy of this completed authorization form.

This form also constitutes authority for you to produce and make photostatic copies of all such records, and to forward same by mail to the approved referenced representative. A photostatic copy of this Authorization shall have the same effect as the original.

This authorization shall remain valid until the claim has been legally concluded for which these records are sought.

_____ _____

Signature of Individual/Legal Representative **Date**

_____ _____

Printed Name of Individual/Legal Representative **Relationship to Individual**

AUTORIZACIÓN PARA DIVULGAR, USAR Y DIVULGAR INFORMACIÓN PROTEGIDA
45 CFR 164.508 y 164.512 (HIPAA)

NOMBRE: FECHA DE NACIMIENTO:

DIRECCIÓN: SS#:

RECLAMACIÓN #:

Autorizo a la disclos Ure y la liberación de toda la información de salud protegida incluyendo, pero no limitado a: ESCRITA MÉDICOS : cualquier y todos los registros médicos, todos ellos en las historias clínicas y ambulatorios y registros, historias clínicas y registros, médico y enfermera notas, emergencia registros de habitaciones, correspondencia, memorandos, registros de fisioterapia y rehabilitación, formularios de cuestionarios de pacientes, formularios de historial del paciente, registros de servicios sociales, registros de laboratorio e informes de diagnóstico. REGISTROS DE PRESCRIPCIÓN : todos y cada uno de los registros de recetas, formularios de recetas médicas originales, registros de recarga y registros de farmacia. FACTURACIÓN: todos y cada uno de los registros de facturación, incluidas las declaraciones detalladas de cargos, pagos, todos los registros de seguros, incluidos todos los reclamos, formularios de reclamo, correspondencia, pagos e informes. REGISTROS DE EMPLEO: todos y cada uno de los registros de empleo, incluida la información salarial y los documentos del personal. REGISTROS DE LA OFICINA: todos y cada uno de los registros de la Oficina de Compensación de Trabajadores para cualquiera y todos los reclamos de compensación de trabajadores. SEGURO DE ARCHIVOS : cualquiera y todos los documentos relativos a cualquier reclamación de seguros que contenga un físico lesiones incluyendo , pero no limitado a , todos los registros médicos, correspondencia, la historia clínica, informes de la policía, libros de pagos y todos los demás documentos contenidos en la demanda (s) de archivo Esta autorización se aplica a todos los registros médicos, lesiones, historial médico, empleo y condición física, independientemente del momento en que ocurrieron, tanto antes como después de mi firma en este formulario, independientemente del momento en que ocurrieron.

La información sobre el VIH, la salud mental y las drogas y el alcohol contenida en las partes de los registros indicados anteriormente se divulgará a través de esta autorización a menos que se indique lo contrario.

No R Elease: _____ VIH _____ _ Mental Health _____ Drogas y Alcohol

Esta información de salud protegida se divulga para el siguiente propósito: **Reclamación de compensación para trabajadores**

Esta información se utilizará con el propósito de verificar, evaluar y / o negociar el reclamo del individuo. Esta información no es necesaria para obtener tratamiento.

Usted está autorizado a divulgar los registros anteriores a los siguientes: Lackawanna Insurance Group y su (s) agente (s) con el fin de obtener registros médicos.

Tengo derecho a revocar esta autorización A, por escrito, enviando una notificación por escrito a la entidad cubierta. Entiendo que mi decisión de revocar la autorización puede resultar en la denegación de mi reclamo de compensación de trabajadores por incumplimiento de una solicitud de registro médico, pero no afectará mi capacidad de obtener tratamiento de ninguna entidad cubierta. Además, entiendo que una revocación no es efectiva en la medida en que haya confiado en mi autorización para divulgar información médica protegida antes de la revocación. Además, entiendo que la información puede volver a divulgarse y no estar sujeta a protección. Entiendo que tengo derecho a:

- Inspeccionar o copiar la información de salud individualmente identificable que se divulgará.
- Negarse a firmar esta autorización, sujeto a las posibles sanciones impuestas por la Ley de Compensación de Trabajadores de Pensilvania y su Reglamento.
- Que tengo derecho a una copia de este formulario de autorización completado.

Este formulario también constituye autoridad para que usted produzca y haga copias fotostáticas de todos esos registros, y que los envíe por correo al representante de referencia aprobado. Una copia fotostática de esta Autorización tendrá el mismo efecto que el original.

Esta autorización seguirá siendo válida hasta que el reclamo haya sido legalmente concluido para lo cual se buscan estos registros.

_____ _____

Firma del Representante Individual / legal **Fecha**

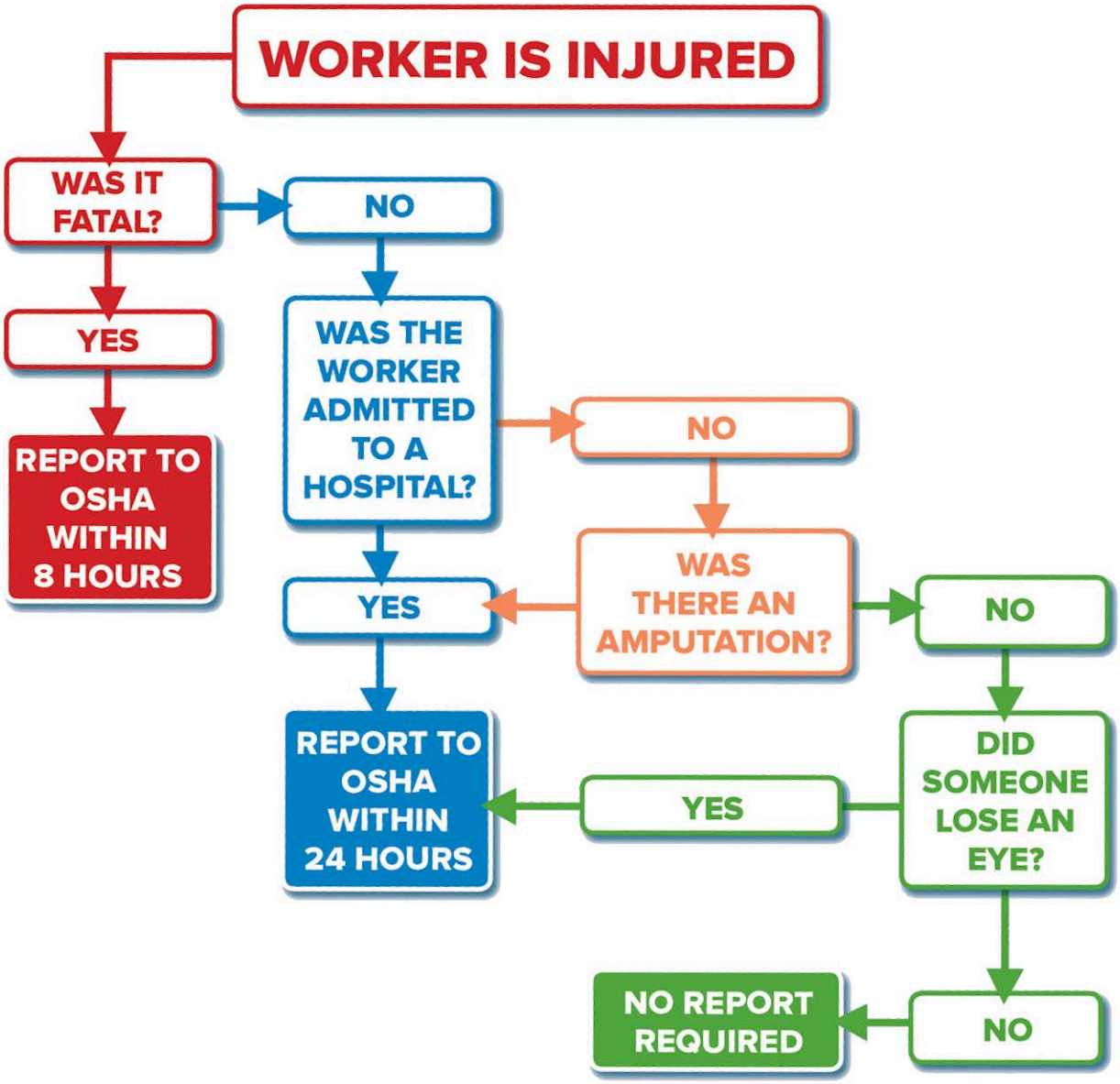
_____ _____

Nombre impreso del individuo / representante legal **Relación con el individuo**

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.

OSHA®'s NEW REPORTING EXPLAINED



HOW DO I REPORT?

Call 1-800—321-OSHA (6742) or your local OSHA office
Report online at www.osha.gov/report_online

Cost Containment Programs

When an employer develops and implements cost containment programs it can assist the policyholder in mitigating costs associated with workers' compensation insurance.

Lackawanna Insurance Group recommends a policyholder consider implementing at least the following Cost Containment Programs:

- **Designated Provider Panel Program**

The PA Workers' Compensation Act gives employers the right to establish a list of designated healthcare providers. When the list of designated healthcare providers is properly posted and the employer provides a clearly written notice to employees of their rights and duties, injured workers must seek treatment for a work injury or illness with one of the designated providers for 90 days from the date of the first visit.

As an added benefit to our policyholders, Lackawanna Insurance Group provides the services of Premier Comp Solutions (PCS) to develop functional provider panels. Please contact PCS @ (888) 594-4001 to develop a panel that meets your specific needs. Once a panel is created, PCS can provide appointment scheduling services (24/7), and access to discounted physical therapy and diagnostic services networks.

- **Pharmacy Program**

Lackawanna Insurance Group has partnered with Optum as our preferred provider of pharmacy benefit management services. Injured employees are automatically enrolled into the program once a claim is submitted and open.

As an added advantage, policyholders can enroll in Optum's First Fill program that provide injured employees immediate access to medications needed to treat an initial injury, even before a claim is established.

- **Return to Work Program**

Employers are encouraged to establish a return to work program. By providing modified/restricted duty work employers can reduce workers' compensation costs, avoid costs of hiring and training a replacement worker, reduce fraud, and promote employee morale. More importantly, it has been recognized that employees have a quicker recovery rate and a better outcome when they continue to work with limitations/restrictions during their healing and recovery period.

The Pennsylvania Department of Labor & Industry Workers Compensation Services provides Pennsylvania employers with the process of establishing Return-to-Work programs; Return-to-Work; A Model for Pennsylvania Business & Industry; https://www.dli.pa.gov/Businesses/Compensation/workplace-comm-safety/ReturnToWork/Pages/Table-of-Contents.aspx

First Fill® Program

The First Fill program allows injured workers to obtain necessary medications, prescribed at the time of initial treatment, for their work-related injuries without any out-of-pocket expenses.

Offered by Optum, our pharmacy benefits manager, the First Fill Program is part of the Lackawanna Insurance managed care pharmacy program and is the first step in helping injured workers recover and return to work.

Benefits for Employers

- Directs injured workers to a network pharmacy for better medication utilization management
- Ensures injured workers receive the most appropriate medication for their injury at the right time
- Assists in controlling prescription medication costs

Benefits and Information for Employees

- Automatic enrollment in the program
- First Fill card provided by employer when injured worker seeks initial medical treatment
- No out-of-pocket expenses for injured worker
- First Fill card accepted at nearly 70,000 pharmacy locations nationwide including all major pharmacy chains and most neighborhood pharmacies

Program Limitations

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

It's Easy to Enroll

To use, download this document.

- Enter Employer/policy holder name in the editable "Employer" field.
- Print and provide to your injured worker when needed with the editable name and date of injury fields completed.

If you have any questions, please contact your Lackawanna Insurance claims representative or our Optum Account Manager at **Danielle.Jackson@optum.com**

OPTUM®

LACKAWANNA INSURANCE GROUP

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum 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 an Optum 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 and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

LACKAWANNA INSURANCE GROUP

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Lackawanna Insurance Group
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	LACKFF		

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.

tmesys®

IMP14-1614-109-FFWG

OPTUM®

LACKAWANNA INSURANCE GROUP

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM® LACKAWANNA INSURANCE GROUP

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Lackawanna Insurance Group
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	LACKFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG