WAYNESBORO AREA SCHOOL DISTRICT
WHAT TO DO IN CASE OF A WORK-RELATED INJURY

If you suffer a work-related injury, your health and wellbeing are our first concern. If the injury is of a serious nature and requires the assistance of an ambulance or rescue personnel, they should be contacted immediately. If the injury is of a less serious nature, the following procedures must be followed:

1. If you suffer a work-related injury, the first thing you MUST do is report the injury to your principal or supervisor. Telephone **Sharon Levick, HR Secretary @ ext. 1133** and she will provide you with a School District Insurance Consortium, hereinafter referred to as SDIC, packet. Prior to receiving the packet, employees are to call SDIC @ 1 (800) 445-6965, ext. 101 to report the injury.

2. If you require a prescription for your work-related injury or disease, do not use your personal health plan prescription card. Please use the Mitchell International Pharmacy Sheet, which you will receive in the claim package. When you call in your report of injury to SDIC, they will assign you a claim number. Please use this claim number when seeing a panel physician.

3. If you suffer a work-related injury, **Waynesboro Area School District** or our insurer will pay reasonable surgical and medical services and supplies, orthopedic appliances and prosthetics, including training in their use when needed. In order to insure that your medical treatment will be paid for by **Waynesboro Area School District** or our insurer, **you must select from one of the health-care providers listed below for your initial care**:

Summit Occupational Health
1610 Orchard Drive
Chambersburg, PA 17201
(717) 261-0929
Area of Specialty: Occupational Medicine

Summit Orthopedic Group
Chambersburg Medical Building
120 North 7th Street, Suite 101
Chambersburg, PA 17201
(717) 263-1220
Area of Specialty: Orthopedics

Ludwick Eye Center
825 5th Avenue, Suite 102
Chambersburg, PA 17201
(717) 262-9700
Area of Specialty: Ophthalmology

For Physical Therapy:
NovaCare Rehabilitation
For the nearest facility contact:
(866) 723-NOVA (central scheduling)

One Call Care Management(Align):
(866) 389-0211
Area of Specialty: Chiropractic/ Physical Therapy

Waynesboro Family Medical Associates
Welty Medical Building
1051 East Main Street, Suite 1
Waynesboro, PA 17268
(717) 762-9118
Area of Specialty: Family Medicine

Waynesboro Internal Medicine
1051 East Main Street, Suite 2
Waynesboro, PA 17268
(717) 762-3050
Area of Specialty: Internal Medicine

Dental – One Call Care Management:
(888) 539-0577

For MRI/EMG/X-Ray/CT Scan
One Call Care Management
For the nearest facility contact:
(800) 453-0574 (central scheduling)

For Durable Medical Equipment:
One Call Care Management
(800) 848-1989
Equipment: wheelchairs, walkers, crutches, TENs units, orthotics & prosthetics, etc.

For Prescriptions: Please use your Mitchell International card at your local pharmacy to bill SDIC directly (Giant, CVS, Rite Aid, Wal-Mart, Walgreens, Acme)

4. Please call in advance for an appointment if you need treatment. You must continue to treat with one of these providers for ninety **(90 days)** from the date of your first visit.

5. If, after this ninety (90) day period, you still need treatment and the **Waynesboro Area School District** has provided this list as set forth above, you may choose to continue with this health care provider, or you may choose another provider. You must notify **Sharon Levick, HR Secretary** of this action within five (5) days of your first visit to the health care provider of your choice. Your bills will be paid if you have provided proper notice, and if your provider files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)

6. If one of the health care providers listed above refers you to a specialist, our insurer will pay for these services as provided by law.

All workers' compensation claims will be processed on behalf of the School District by:

SCHOOL DISTRICTS INSURANCE CONSORTIUM
P.O. BOX 1249
NORTH WALES, PA 19454
Phone: (800) 445-6965

EMPLOYEE

INSTRUCTIONS FOR CLAIMS REPORTING

Please read the entire contents of the packet and follow directions below.

1. Call **1-800-445-6965** to report your work-related claim as soon as possible.

2. Advise your Workers' Compensation Coordinator that you have reported your work-related claim.

3. You must seek medical treatment for your claimed injury with one of the providers listed on your **POSTED PANEL** for ninety (90) days from the date of your first visit.

4. Please use the enclosed Pharmacy Sheet and temporary pharmacy card. You may fill your prescription at your local Walgreen's, CVS Pharmacy, Rite Aid, Wal-Mart, Giant, Acme. The Mitchell International, our pharmacy management company, will send you a personalized pharmacy card for future prescriptions. **Mitchell Script Advisor** can be reached at: 1-800-848-4050.

5. Please provide your claim number and SDIC's address to all medical providers.

6. Please complete the enclosed documents as promptly as possible.

7. Please notify your **Claims Representative at SDIC** and your **Workers' Compensation Coordinator** immediately when you receive a **return to work date.**

Please call **1-800-445-6965** if you need any assistance or have questions regarding your work-related injury.

School Districts Insurance Consortium
P.O. Box 1249
North Wales, PA 19454

1-800-445-6965

WORKERS' COMPENSATION REPORT
EMPLOYEE/SUPERVISOR/WITNESS

Note to Employee: All areas of this report must be completed. Otherwise, it will be returned to you and delay the processing of your claim.

If you are unable to return to work because of your injury, you MUST contact the Business Office by the following business day. Failure to do so could jeopardize your claim.

Name	Soc. Sec. #	Date of Accident	Date of Hire	Date of Birth

Address:

Number Street Apt.# City State Zip Code

Phone Number (Include area code)	Accident Reported to: Title:
Building where Injured: School District: Contact: ________	Other Employer(s): Address: Position:

Describe Accident/Injury:

Have you returned to work? (circle one) YES NO If YES, when?

Date of first treatment: ________ Are you still under treatment? (circle one) YES NO Medical treatment was received from: ________	List prior injuries or conditions:

Employee Signature: Date:

WITNESS' REPORT
Witness Name: (Please Print)
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO
If you are unable to confirm the claimant's version of the accident, please explain why:

Witness' Signature: Date:

SUPERVISOR'S REPORT
Supervisor's Name: (Please Print) ________________
This employee reported the above incident to me on:
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO

If you are unable to confirm the claimant's version of the accident, please explain why:

List recommendations to prevent recurrence:

Supervisor's Signature: Date:

EMPLOYEE'S RIGHTS AND DUTIES UNDER SECTION 306(F.1) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

If you are injured while at work and need medical treatment, you are required to visit one of the health care providers on the list designated by your employer. This duty continues for 90 days from the date of your first visit with a provider on that list, or from the date of any emergency treatment, whichever is earlier.

All reasonable and necessary medical treatment and supplies (such as medicines and prosthetics) that you need as a result of the injury will be paid for by the employer if the treatment is prescribed by a designated health care provider during the 90 day period. Charges for treatment and supplies are specified by the Workers' Compensation Act. You are not responsible for paying any charges that exceed those specified by the Act.

During the 90 day period, you may change from one designated health care provider to another provider on the list, and the treatment will be paid for by the employer.

If the designated health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider. However, any subsequent non-emergency treatment must be provided by a designated health care provider for the remainder of the 90 day period.

If a designated health care provider recommends invasive surgery, you may obtain a second opinion from a health care provider of your choice. Your employer will pay for the cost of this opinion. If this opinion differs from the opinion of the designated health care provider and sets out a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment, however, must be provided by a designated health care provider for 90 days from the date of the visit to the non-designated health care provider.

After the 90 day period has ended, you have the right to seek treatment from any physician or health care provider. Your employer will pay for this treatment if it is reasonable, necessary, and related to your work injury. However, you must notify your employer of treatment by a non-designated health care provider within 5 days of your first visit to this provider. Your employer is not required to pay for treatment by a non-designated health care provider before you give this notice. Once you have given this notice, your employer shall pay for this treatment unless the treatment is found to be unreasonable or unnecessary, or unrelated to your work injury.

By signing this form, you acknowledge your rights and duties. You may not refuse to sign this form in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or (717) 783-5421.

I acknowledge that I have been informed of and understand the above rights and duties.

______________________________ ______________________________

Employee Signature Date

______________________________ ______________________________

Employer's Representative Signature

SDIC Workers' Compensation Medical Information Release And Employment Record Release

EMPLOYER #: ________________ CLAIM #: ________________________

EMPLOYEE'S NAME: ____

EMPLOYEE'S SOCIAL SECURITY NUMBER: ____________________________

NAME OF SCHOOL DISTRICT: ____

Dear Medical Services Provider/Employer:

This will authorize you to disclose to SDIC (School Districts Insurance Consortium), or its representatives, any and all information that you may have regarding my condition while under your treatment at any time. This authorization specifically includes my medical history findings, consultations, prescriptions, treatments, x-rays, special consultation reports, diagnosis, prognosis and copies of all hospital records and/or medical records from whatever source. This release also includes employment records, records from the Bureau of Workers' Compensation and prior accident records.

A photostatic copy of this Medical Release shall be considered as effective and valid as the original.

Written authorization shall remain valid for the duration of this claim unless consent is withdrawn in writing.

Employee's
Signature: ______________________________ Date: ________________

Home Address: ____

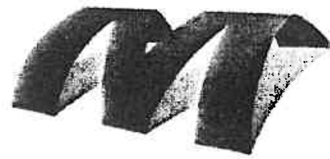
____

____

Employee's Home Telephone Number: ( ) ____________________

School Districts Insurance Consortium
P.O. Box 1249
North Wales, PA 19454
1-800-445-6965

Take to Pharmacy



mitchell

1-800-848-4050

PHARMACY SHEET

SCHOOL DISTRICTS INSURANCE CONSORTIUM
P.O. Box 1249
North Wales, PA 19454
1-800-445-6965

EMPLOYEE INFORMATION SHEET

TAKE TO PHARMACY

Claimant Name: ____________________ Social Security #_____-_____-_____ Date of Birth: ___/___/___

Dear Patient,
On your first visit, please give this information sheet to any participating pharmacy. You can use this sheet at any network pharmacy including **Walgreens, CVS Pharmacy, Rite Aid, Wal-Mart, Acme and Giant.**

Dear Pharmacist,
The bearer of this sheet has prescription coverage through Mitchell Script Advisor; please provide them with the highest level of quality and service. If you have eligibility or drug coverage inquiries please call **Mitchell International** immediately at **800-848-4050.**
Thank you.
Sincerely,
Mitchell International

Pharmacy Submission Information: Group Number – 30011009 Bin #: 600518

Cut out this card

mitchell **Script Advisor**

NAME __________________________ Date ___/___/_____

SS# (MEMBER ID) __________________________

Rx Bin Number #: 600518 PCN: A Rx Group #: 30011009

Authorized Administrator: **SDIC** 800-445-6965

Eligibility and Drug Coverage Inquiries: 800-848-4050
After hours Eligibility + Drug Coverage: 888-454-0265

*****First Fill Maximum: 5 Day Supply*****