WALLINGFORD SWARTHMORE
SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

200 SOUTH PROVIDENCE ROAD, WALLINGFORD, PENNSYLVANIA 19086-6334
PHONE (610) 892-3470 EXT. 1406, 1405, 1401 FAX (610) 892-3497

WORKERS' COMPENSATION CLAIMS REPORTING

In life-threatening situations, immediately seek medical assistance, then complete necessary forms!

All work-related incidents must be promptly reported to the school nurse and Human Resources Department through the following process.

1. **Contact your school nurse** to report the injury and obtain the workers' compensation (WC) claim forms.
2. **Call Human Resources Department** (Eileen at 610-892-3470 extension 1406) to report injury.
3. **Complete and send** the attached ***Internal School District Work-Related Incident Report*** and forms with "**to be completed by Employee**" to the Human Resources Department as soon as possible. A WC claim number cannot be assigned until the claim is submitted to the WC carrier. All notice of injuries must be made within 21 days of the injury to the employee.
4. If medical treatment is required, the employee should refer to attached ***Designated Health Care Providers*** list (panel). You must receive treatment with a panel Physician for the first 90 days of your work injury or illness if you expect WSSD to pay for the medical treatment you receive. Refer to the enclosed ***Workers' Compensation Guidelines for Injured Worker***.
5. Based on the medical provider's direction, the employee shall return to work on full or modified duty or follow the instructions for additional medical treatment.
6. **Give** your supervisor the ***Supervisor's Workers' Compensation Incident Investigation Report*** form to complete and forward to Human Resources Department.

Please call Human Resources (Eileen) at 610-892-3470 extension 1406 if you have questions regarding you work-related injury.

All work related injury claims are coordinated through:

CM Regent Insurance Company – WC Division
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050

7-23-18

SECTION ONE! Completed by Employee.

CM REGENT™
INSURANCE COMPANY
Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:	Employer Address:	County:
Employee Name (last, first, initial):	Home Phone #:	Gender: M ☐ ☐ / Marital Status: M ☐ F ☐ Dep.:
Home Address (street, city, state, zip code):		County:

Social Security #:	DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:

Location of Incident (building, room, etc.):	Type of Injury (cut, sprain, etc.):
Injured Body Part:	Cause of Injury (machine, tool, equipment, liquid, etc.):

Employee's Job Title:	Hours Worked Per Week:	Name of Witness(es):

Description of Incident (please describe in detail what happened):

Employee Name:	Employee Signature:	Date:
Employee's Supervisor Name:	Employee's Supervisor's Signature:	Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: _____ ☐ New ☐ Other (describe): _____

Treatment/First Aid: _____

Diagnosis: _____

Disposition: _____

☐ Return to work without limitations

☐ Return to work with limitations (describe): _____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Signature of medical/first aid provider _____ **Date:** _____

Medical Facility Address:

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
(866) 402-6600 Fax: (866) 402-6601 www.CMRegent.com

To be completed by EMPLOYEE.

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM - SIDE 2

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

To be completed by Employee.

Medical Authorization Form

Injured Worker: _____

Claim Number: _____

Date of Injury: _____

School District: _____

Your Workers' Compensation claim is in the process of being submitted to CM Regent Ins. Co. A Claim Representative will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Ins. Co. at (866) 402-6600.

If you require the following services, please contact the designated providers:

- MRI, CT, EMG – contact One Call Medical @ 800-453-0574
- Physical Therapy – contact SPNET @ 888-654-0049
- Prescriptions – contact Corvel @ 800-563-8438

Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.

Thank you for your cooperation.

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize CM Regent Ins. Co. and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.

This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.

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

Sign: _____ Date: _____

Date of Birth:_____

Claim Number:_____-

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.

WALLINGFORD SWARTHMORE
SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

SUPERVISOR'S WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT

(Must be **completed by the supervisor**, not the employee, and returned to Eileen Seichepine in Human Resources)

Note: The information provided in this report will be used to promote a safer working environment for all employees by identifying unsafe work practices or conditions and investigate the conditions by which the claim was reported.

PLEASE PRINT

Employee name _____ Date of injury _____

Location of injury: _____

1. What is the Employee's description of the occurrence?

_____

_____

_____

_____

2. Describe the resulting injuries:

_____

_____

_____

3. Was personal protection equipment or guards provided for this activity? __ yes __ no
4. Was the personal protection equipment or guards being used at the time? __ yes __ no
5. Should personal protection equipment or guards be provided for this activity? __ yes __ no
6. Are there safety rules that apply to this activity? __ yes __ no
7. How could this incident have been prevented?

_____

_____

_____

8. What was the last day worked? _____
9. Was there a third party involved causing the accident? __ yes __ no
   If yes; Student, Employee, Other
10. Witness Name(s): _____

_____

11. Explain in detail what actions could be taken to correct the unsafe act or condition.

_____

_____

_____

Supervisor signature _____ Date _____

Wallingford-Swarthmore School District

Workers' Compensation Program: Designated Health Care Providers

The following procedures must be followed in case of work related injury or illness:

A. Immediately report the injury to your supervisor.
Any injury you sustain at work must be reported immediately to your supervisor & Human Resources Office. Failure to do so may delay your benefits or cause you to lose your rights to benefits.

B. Obtain medical care from a provider listed below.

PROVIDER	ADDRESS	PHONE NUMBER	SPECIALITY
1. Care Stat Urgent Care (2 Locations)	213 Morton Avenue, Folsom (Ridley Twp.) PA 19033 or 1305 West Chester Pike, Havertown, PA 19083	610-482-4949	OCCUPATIONAL MEDICINE
2. AFC Doctors Express Urgent Care	5024 Pennell Road Aston, PA 19014	484-766-3502	URGENT CARE
3. Patient First	417 Baltimore Pike, Springfield, PA 19064	484-470-2600	URGENT CARE
4. Urgent Care @ Park Care	8 Morton Avenue Suite 206, Ridley Park, PA 19078	610-595-6811	OCCUPATIONAL MEDICINE
5. Crozer Centers for Occupational Health - Springfield	196 West Sproul Road Suite 210 Springfield, PA 19064	610-328-8760	OCCUPATIONAL MEDICINE
6. WORKNET	100 Diplomat Drive, Lester, PA 19113	610-521-6880	OCCUPATIONAL MEDICINE
7. The Back and Neck Pain Relief Center - Joseph R. Schneider, DC	477 Baltimore Pike Springfield, PA 19064	610-544-9800	CHIROPRACTIC
8. One Call Care Dental and Doctor	For the nearest location, please call the toll free number.	888-539-0577	DENTIST
9. Springfield Hospital or Crozer-Chester Medical Center	190 West Sproul Rd., Springfield, PA 19064 or One Medical Center Blvd., Upland, PA 19013	610-447-2821 610-447-2000	HOSPITAL ACUTE
10. Ophthalmic Associates	8 Morton Avenue, Suite 101, Ridley Park, PA 19078	610-521-2111	OPHTHALMOLOGY
11. Rothman Institute - Ro (Robert Frederick, MD)	1118 West Baltimore Pike Media. PA 19063	267-339-3776	ORTHOPEDIC SURGERY
12. Rothman Institute - Ro (Christopher J. Mehallo, MD)	1118 West Baltimore Pike Media. PA 19063	267-339-3776	SPORTS MEDICINE
13. Premier Orthopaedics/ Associates Division	200 E. State Street, Suite 108, Media PA 19063 or Crozer: 1 Medical Center Blvd., Suite 324, Upland PA or Brinton Lake: 300 Evergreen Dr., Suite 200, Glen Mills, PA	610-876-0347	ORTHOPEDIC SURGERY
14. Premier Orthopaedics / Liberty Division	Jones Medical Building, 1 Bartol Avenue, Ridley Park, PA 19078	610-521-8970	ORTHOPEDIC SURGERY
15. Rothman Institute	1118 West Baltimore Pike Media, PA 19063	267-339-7824	ORTHOPEDIC SURGERY
16. Corvel	Available at any major pharmacy	800-563-8438	PHARMACY/DME
17. SPNet Clinical Solutions	Physical Therapy	888-654-0049	PHYSICAL THERAPY
18. One Call Medical	MRI, CT, EMG	800-453-0574	RADIOLOGY

C. Medical Emergency:
If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. If you choose to treat with an out of state provider, you may be subject to balance billing.

E. For medical treatment to be paid by your employer:

1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

CM Regent Insurance Company – Workers Compensation Division
300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
Phone 866-402-6600: Fax 866-402-6601
07/01/2018
For medical groups, all providers are eligible to render medical services.

To be completed by Treating / Panel Physician (not employee)

CM REGENT™ INSURANCE COMPANY

Patient Name: _____
Date of Birth: _____
Claim#: _____

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions

(Hours at one time)				(Total hours during day)			
☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-5	6-8	0-2	2-4	4-6	6-8

2. In an 8-hour workday, patient can sit: ☐ No restrictions

(Hours at one time)				(Total hours during day)			
☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-5	6-8	0-2	2-4	4-6	6-8

3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions

(Minutes at one time)		(Hours at one time)
☐	☐	☐
10-30	30-60	1-3

4. Patient can lift/carry: ☐ No restrictions or above

Maximum lbs.:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Patient can use hands for repetitive: ☐ No restrictions

A. Simple Grasping		B. Pushing & Pulling		C. Fine manipulation	
☐	☐	☐	☐	☐	☐
Yes	No	Yes	No	Yes	No

6. Patient can use feet for repetitive movement as in operating foot controls: ☐ No restrictions
☐ Yes ☐ No

7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
☐ No restriction
☐ Yes – Please explain _____

9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
☐ No restriction
☐ Yes – Please explain _____

10. When will patient be released to return to work:

Light duty _____ Full duty _____

11. Will patient be required to use any assistive devices or braces?
☐ No restrictions
☐ Yes – Please explain _____

_____

12. Additional comments: _____

_____

_____ _____
Physician's Signature Date

Thank you for your assistance,

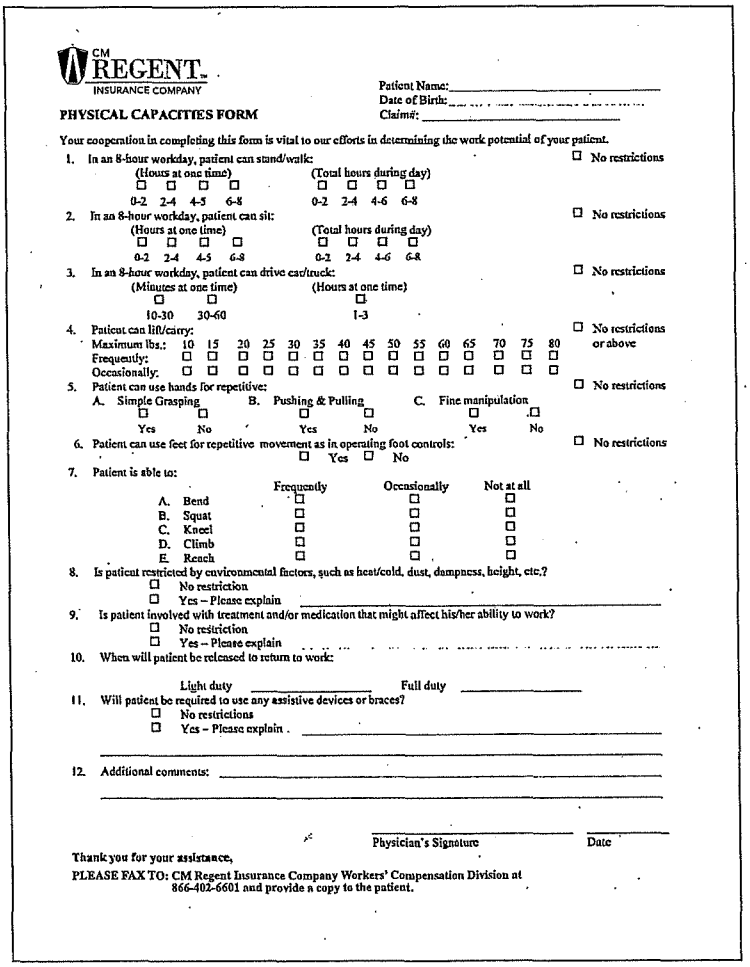
PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.

Physical Capacities Form

What Is It: Form completed by treating/panel physician (at time of injury and ongoing throughout course of treatment of work injury) with a detailed breakout of what the current physical abilities are of the injured worker (IW) in order to attempt to allow IW to remain in the workforce.

Importance: Provides immediate update to employer and Claim Representative as to what the IW is able to do with respect to his/her work duties and/or provides assistance to employer in developing transitional duty (if applicable).

How Form Is to Be Used: Upon notification of an injury that requires treatment, provide form to injured worker and to the panel doctor for completion by treating/panel physician.



CM REGENT INSURANCE COMPANY

Patient Name: _____
Date of Birth: _____
Claim#: _____

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions
   (Hours at one time) ☐ ☐ ☐ ☐ 0-2 2-4 4-5 6-8
   (Total hours during day) ☐ ☐ ☐ ☐ 0-2 2-4 4-6 6-8
2. In an 8-hour workday, patient can sit: ☐ No restrictions
   (Hours at one time) ☐ ☐ ☐ ☐ 0-2 2-4 4-5 6-8
   (Total hours during day) ☐ ☐ ☐ ☐ 0-2 2-4 4-6 6-8
3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions
   (Minutes at one time) ☐ ☐ 10-30 30-60
   (Hours at one time) ☐ 1-3
4. Patient can lift/carry: ☐ No restrictions

Maximum lbs.:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80 or above
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Patient can use hands for repetitive: ☐ No restrictions
   A. Simple Grasping ☐ Yes ☐ No
   B. Pushing & Pulling ☐ Yes ☐ No
   C. Fine manipulation ☐ Yes ☐ No
6. Patient can use feet for repetitive movement as in operating foot controls: ☐ No restrictions ☐ Yes ☐ No
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No restriction
   ☐ Yes – Please explain _____
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No restriction
   ☐ Yes – Please explain _____
10. When will patient be released to return to work:
    Light duty _____ Full duty _____
11. Will patient be required to use any assistive devices or braces?
    ☐ No restrictions
    ☐ Yes – Please explain _____
12. Additional comments: _____

Physician's Signature _____ Date _____

Thank you for your assistance,

PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.

Full-sized form on page

To be completed by PHYSICIAN (if needed)

CM REGENT™
INSURANCE COMPANY
Workers' Compensation Division

TRANSITIONAL DUTY RTW FORM

School District Name: WALLINGFORD-SWARTHMORE SCH. DIST.

School District Address: 200 S. Providence Road, Wallingford, PA 19086

School District Contact: Human Resources - Eileen Seichepine - Benefits

School District Phone Number: 610-892-3470 x 1406 Fax Number: 610-892-3497

Employer: Provide this form to the attending Physician

*****REMINDER TO MEDICAL PROVIDER*****

EMPLOYEES ARE OUR MOST VALUABLE ASSET!

WE OFFER MODIFIED DUTY!

It is the policy of Wallingford-Swarthmore S.D. to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding our modified duty program, please contact us.

Thank you!

(To be completed by the Physician)

_____ Yes, employee may return to work on regular duty (no restrictions).

_____ Yes, employee may return to work on modified duty (see restrictions).

_____ No, employee may NOT return to work (see restrictions).

Physician's Signature: _____

Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
866-402-6600 Fax: 866-402-6601 www.cmregent.com

WALLINGFORD SWARTHMORE SCHOOL DISTRICT

HUMAN RESOURCES DEPARTMENT

WORKERS' COMPENSATION GUIDELINES FOR INJURED WORKER

Employee Obligations:

- Report of injury by employee to designated person within the Company. Notice of the injury must be made within **21 days** of the injury or within 21 days of the employee's knowledge of a condition and its relationship to his/her employment. (This could be a medical condition the employee is suffering from which is not medically diagnosed as being related to the employment until a later time).
- Treatment with a Panel Physician for a period **90 days** from the date of the initial treatment.
- All periods of **disability must be medically authorized** by a physician.
- Employee must **attend scheduled medical appointments** or the disability for the time periods appointments are missed will be considered unauthorized.
- Employee must provided employer with **documentation supporting the injury** and the **related disability**.
- Employee must report any outside **earnings from concurrent or subsequent employment** at the time of injury or at the time the employment begins. **(Failure to do so constitutes an act of Fraud and is subject to penalties under the WC Act).**
- Employee must **report any increase in earnings** from alternative employment during the duration of any periods of disability. **(Failure to do so constitutes an act of Fraud and is subject to penalties under the WC Act).**
- Employee must notify the employer within **5 days of any change of physician** care.
- Employee must **notify the employer of any pursuit of a third party action** against a third party who may have caused a work-related injury. (There is a right of recovery against a responsible third party, in which the employers'/carriers right to recover is first, absolute and non-waivable).
- Employee must attend an **Independent Medical Evaluation** at the request of the employer/carrier not to exceed two times in a 12-month period.
- Employee must notify the employer of **all treating physicians** relating to a specific injury.
- Employee must provide **documentation of any release to return-to-work** restricted or full release.

NOTICE TO EMPLOYEES

of Workers' Compensation Insurance for Industrial Injuries and Diseases

The undersigned, an employer subject to the provisions of the Workers' Compensation Act of Pennsylvania hereby gives notice to its employees and to all other persons interested, that it has secured the payment of the compensation payable to its employees and their dependents, by insuring with the **CM Group**.

Claims and requests for information are to be addressed to:

CM Regent Insurance Company
Workers' Compensation Division
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050
www.cmregent.com
Toll-free: 866-402-6600
Fax: 866-402-6601

BUREAU CODE # 2389

Expiration Date of Policy – July 1, 2019

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

CM REGENT™
INSURANCE COMPANY

Injured Worker's First Fill Prescription Form

Claimant Name: _____

Date of Injury: _____ SSN: _____

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one time fill of prescription medications. For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by **CM Regent Insurance Company.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14 day supply of medications.

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC7277479**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's 9 digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

Below is a sample listing of some of the over 72,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL

U.S. Food and Drug Administration
Drug Safety Communication

Safety Announcement
The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. We are requiring changes to the labels of all opioid drugs to warn about these risks.

More specifically, the labels will warn about the following:

- Opioids can interact with antidepressants and migraine medicines to cause a serious central nervous system reaction called serotonin syndrome, in which high levels of the chemical serotonin build up in the brain and cause toxicity.
- Taking opioids may lead to a rare, but serious condition in which the adrenal glands do not produce adequate amounts of the hormone cortisol. Cortisol helps the body respond to stress.
- Long-term use of opioids may be associated with decreased sex hormone levels and symptoms such as reduced interest in sex, impotence, or infertility.

Opioids are a class of powerful narcotic pain medicines that are used to treat moderate to severe pain that may not respond well to other pain medicines. They can help manage pain when other treatments and medicines are not able to provide enough pain relief, but they also have serious risks including misuse and abuse, addiction, overdose, and death.

Facts about Opioids

- Opioids are powerful prescription medicines that can help manage pain when other treatments and medicines are not able to provide enough pain relief. However, opioids also carry serious risks, including of misuse and abuse, addiction, overdose, and death.
- Prescription opioids are divided into two main categories – immediate-release (IR) products, usually intended for use every 4 to 6 hours; and extended release/long acting (ER/LA) products, intended to be taken once or twice a day, depending on the individual product and patient.
- Certain opioids, such as methadone and buprenorphine, can also be prescribed as a form of treatment for opioid addiction.
- Opioids are available in many different formulations, including tablets, capsules, lozenges, sublingual tablets, transdermal patches, nasal sprays, and injections.
- Common side effects of opioids include drowsiness, dizziness, nausea, vomiting, constipation, physical dependence, and slowed or difficult breathing.
- The risk of opioid addiction, abuse or misuse is increased in patients with a personal or family history of substance abuse, or mental illness.
- It is important to lock up opioids and to dispose of them properly to keep them from falling into the wrong hands.