

Employee Acknowledgement

Employer: **Wilson School District**

In Pennsylvania, 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.

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.

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

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

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

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.

I also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306(f.1)(1)(I) of the Pennsylvania Workers' Compensation Act. My rights and duties include the following:

1. I recognize and agree that my employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). I further agree that my employer has provided the name, address, telephone number, and area of medical specialty of each designated provider on the list.
2. I have the duty to obtain treatment for work-related illnesses from one or more of the designated health care providers listed below for ninety (90) days from the date of first visit to a designated provider.
3. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
4. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
5. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.

6. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period.
7. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.
8. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.
9. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and,
10. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the procedure shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion).

I, _____, employee of _____, hereby certify that I was provided with the above statement and attached Provider Panel.

Employee Signature

Date

Witness Signature

Date

Coverage is underwritten by Highmark Casualty Insurance Company, Pittsburgh, PA, or HM Casualty Insurance Company, Pittsburgh, PA. Highmark Casualty Insurance Company may provide certain administrative and customer support services. The coverage or service requested may not be available in all states.

Wilson School District

Physician Panel

Occupational Medicine

US Healthworks Medical Group of PA
1114 Commons Blvd
Reading, PA 19605
(610) 926-0960

Concentra Medical Centers
4201 Pottsville Pike
Reading, PA 19605
(610) 921-5811

WORKNET Occupational Medicine
3225 N. 5th Street Highway, Suite 4
Reading, PA 19605
(610) 939-2391

Occupational Health Services of The Reading Hospital
1000 Tuckerton Court
Reading, PA 19605
(484) 628-4000

Surgery

Flynn & Hanley Surgical Associates
301 S 7th Avenue
Reading, PA 19611
(610) 375-4381

Orthopedics

Berkshire Orthopedics
2201 Ridgewood Road, Suite 250
Reading, PA 19610
(610) 375-4949

Commonwealth Orthopedic Associates
1235 Penn Avenue
Wyomissing, PA 19610
(610) 779-2663

Ophthalmology

Carim Eye & Retina Center, LTD
2630 Westview Drive
Wyomissing, PA 19610
(610) 376-1981

Chesen Eye & Laser Center
301 Penn Avenue, Suite 100
Reading, PA 19611
(610) 372-2222

Chiropractic

Mark Cavallo
1114 Commons Blvd
Reading, PA 19605
(610) 926-0960

Wyomissing Chiropractic Center
904 Penn Avenue
Wyomissing, PA 19610
(610) 374-7704

Physical Therapy

Premier Comp PT Network
Call Toll Free for Closest Location
1-888-594-4001

Pharmacy

Proceed to participating pharmacy with RX card, call
1-877-444-4644 if you need assistance or if you do not have a
card.

Diagnostic Testing

Premier Comp Solutions
Call Toll Free for Closest Location
1-888-594-4001

Durable Medical Equipment Facility

Cypress Care
1-800-419-7191

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