UPMC work partners

NOTICE TO EMPLOYEES
Health Care Provider Panel and Procedures

IN CASE OF A WORK INJURY OR ILLNESS:
1. You must immediately report the injury or illness to your supervisor.
2. To report the injury/illness the employee's supervisor/manager is responsible for calling Human Resources at 412-397-6279. All injuries/illnesses must be reported to Human Resources no later than 24 hours after the injury/illness. All correspondence and bills must be directed to:

UPMC WORK PARTNERS
Claims Management Services
PO Box 2971
Pittsburgh, PA 15230
Fax: (412) 454-8717

3. To ensure that bills associated with medical treatment will be paid by UPMC Work Partners, you must select from one of the licensed physicians or health care providers listed below.

If there are any questions concerning this notice, please call 1-800-633-1197.

REQUIRED NOTICE OF EMPLOYEE RIGHTS AND DUTIES

(1) The employee has 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.

(2) The employee has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.

(3) The employee has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.

(4) The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.

(5) The employee has the right to seek emergency medical treatment from any provider, but that subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.

(6) The employee has the right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.

(7) The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.

(8) The employee has the duty to notify the employer of treatment by a non-designated provider 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. However, the employer shall pay for these services once notified, unless that treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).

(9) The employee has the right to seek an additional opinion from any health care provider, of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

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WORKERS' COMPENSATION INFORMATION

To All Employees:

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 if 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. It is also required to be posted in any areas used for 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:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer.

I, _____, employee of _____,
(employer)
certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Email this form to hnatkovich@rmu.edu or fax to 412-397-2555.

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EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

_____

Employee's Signature Date

_____

Employee's Name (Print) Employee Number

_____

Employer Department

_____

Witness' Signature Date

Email this form to hnatkovich@rmu.edu or fax to 412-397-2555.