ENCOVA INSURANCE INJURY KIT

PENNSYLVANIA

POLICY # _____

COMPANY NAME _____

CONTACT PERSON AND NUMBER _____

_____

JURISDICTION _____

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ENCOVA INJURY KIT SUPERVISOR CHECKLIST

- [ ] Secure proper medical care for your employee and inform them if modified/light duty work is available.

- [ ] Follow your company's procedure to report the injury. If you are not aware of the procedure, call your supervisor.

- [ ] Give this envelope to your employee and ensure they complete the enclosed forms.

- [ ] Report the injury to Encova within 24 hours using one of the following methods:

  - **Internet:** File electronically through Encova Edge; contact your agent or Encova's Customer Service Unit for information about becoming an Encova Edge user
  - **Phone:** Call 844-362-6821, select "policyholder" and option 1 (This is the quickest and most convenient option)
  - **Email:** Send an email with the completed First Report of Injury as an attachment to claimsintake@encova.com; visit the specific jurisdiction's website to obtain the First Report of Injury form
  - **Fax:** Send the completed First Report of Injury to 877-293-5513 or 304-941-1151; visit the specific jurisdiction's website to obtain the First Report of Injury form

If you have an Encova Edge account, you can click the Virtual Claims Kit link, choose the appropriate carrier and jurisdiction and locate the correct form.

INJURED EMPLOYEE CHECKLIST

- [ ] Report all injuries to supervisor

  (Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)

- [ ] Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)

- [ ] If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form

- [ ] If not released to return to work, you must call your supervisor within one business day and provide:
  - Physician's name, address and phone number
  - Date of your next scheduled doctor appointment

- [ ] Return Incident Report to your supervisor upon return or within 24 hours

Mitchell ScriptAdvisor

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by **Encova Insurance** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, Mitchell ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: **Process through Script Care and Enter RxBIN, RxPCN and GROUP.**

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001536TC

Walmart · RITE AID · Longs Drugs · CVS pharmacy · TARGET · Walgreens · SAFEWAY

Questions?
Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International
866.221.6588

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MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

HIV/AIDS	Behavioral health	Drug and alcohol	Genetic history
_____	_____	_____	_____

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____ . If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ Signature of individual

_____ Date

_____ Social Security number

_____ Date of birth

_____ Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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CLAIM FILING FORM

(Compatible with Encova Edge claim filing and OSHA Form 301 filing)

** Denotes required field*

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of injury: *	Policy number:	Policy name:	Case # from OSHA Log (if applicable):
Filing date:	Claim type: * ☐ Incident ☐ Indemnity ☐ Medical only		Jurisdiction:

POLICY / DEMOGRAPHIC QUESTIONS

What is your name? *		What is your job title?		
What is your telephone number? *	What is your fax number?	What is your email address?		
Are you the contact for this claim? ☐ No ☐ Yes		If no, who should we contact for additional information?		
What is the contact's phone number?		What is the contact's email?		
Is this a Federal Longshore (USL&H) claim? ☐ No ☐ Yes		Are you reporting a fatality? ☐ No ☐ Yes		Date of death: *
Date of injury/date of last exposure: *		What is your policy number? *		
What is the employee's ID type? * ☐ Employment Visa number ☐ Green Card number ☐ Passport number ☐ Social Security number		ID number: *		
What is the employee's name?	First: *	MI:	Last: *	Suffix:
What is the employee's mailing address? Street/P.O. Box: *				
Zip: *	City: *	State: *	Country:	
What is the employee's physical address? Street/P.O. Box:				
Zip:	City:	State:	Country:	
What is the employee's primary telephone number?		What is the employee's alternate telephone number?		
What is the employee's regular work schedule?				

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's date of birth? *		Gender: * ☐ Male ☐ Female ☐ Unknown				
Marital status: * ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common law ☐ Unknown						
What is the industrial code? *		What is the job title? *				
Description of employee's job and regular duties:						

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's hire date? *	What is the state of hire for this employee?
Employment type: ☐ Full-Time ☐ Part-Time ☐ Volunteer	Is the employee: An officer? ☐ No ☐ Yes An owner/part owner? ☐ No ☐ Yes
What is the hourly rate of pay for this employee?	What are the number of hours worked per week for this employee?

What is the daily rate of pay for this employee?	How many hours per day did the employee work?	How many days per week did the employee work?

Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?

Is the employee continuing to receive full wages? ☐ No ☐ Yes

INJURY QUESTIONS

What is the primary work location? *
Name:

Address: *			Country:
Zip: *	City: *	State: *	

What is the reporting location?

Did the accident occur on the employer's property? * ☐ No ☐ Yes

If no, where did the accident occur? * Name: *		Address:	
Zip:	City:	State:	Country:

Was this the employee's regular department? ☐ No ☐ Yes	In what department did the accident occur?
Was injury the result of a motor vehicle accident? ☐ No ☐ Yes	Was any equipment involved in the injury? ☐ No ☐ Yes If yes, what equipment?

What was the employee doing just before the incident occurred?

How did the accident occur? *

What object or substance directly harmed the employee?

Was safety equipment provided? ☐ No ☐ Yes	Was safety equipment used? ☐ No ☐ Yes

If yes, what type?

What was the injured body part(s)? *

What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Upper ☐ Not applicable

What is the nature of the injury (sprain, strain, etc.)? *

What was the cause of injury? *

Are you aware of a previous injury to this body part? * ☐ No ☐ Yes
If yes, please explain: *

Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ No ☐ Yes
If yes, please explain: *

Are there outside activities or medical conditions that would affect this injury? ☐ No ☐ Yes
If yes, please explain: *

INJURY QUESTIONS

List all **others** involved in the accident with contact information:

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

List all **witnesses** to the accident (or enter "none"):

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? * (Include a.m. or p.m.)

What time did the accident occur? * (Include a.m. or p.m.)	Who was notified of the accident?
When did the injured worker notify the employer? * (Date)	Did the claimant stop work? ☐ No ☐ Yes

What is the loss type?
☐ Incident only ☐ Indemnity ☐ Medical only ☐ Modified duty with no wage loss ☐ Modified duty with wage loss

What was the last date worked?	What time did the employee stop work? (Include a.m. or p.m.)
Has the employee returned to work? ☐ No ☐ Yes	Date of return to work?
Did/will the claimant return to full duty? ☐ No ☐ Yes	Do you have transitional/modified work available? ☐ No ☐ Yes
Number of hours per week?	Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? ☐ No ☐ Yes	Name of medical provider:

Medical facility/provider's address:

Zip:	City:	State:	Country:

Was employee treated in an emergency room? ☐ No ☐ Yes	Was employee hospitalized overnight as an in-patient? ☐ No ☐ Yes

What was the method of transportation? ☐ Helicopter ☐ Ambulance ☐ Personal vehicle ☐ Other

Do you require your employees to be drug tested? ☐ No ☐ Yes	If yes, when was the employee last tested?
Was an incident report completed? * ☐ No ☐ Yes	Do you have any reason to question this injury? * ☐ No ☐ Yes

Do you have any comments for the record?

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PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name	Claimant number	Date of injury

Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

Standing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Sitting	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Walking	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Climbing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Kneeling	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
	>67% of workday	34% - 66% of workday	6% - 33% of workday	<5% of workday	0% of workday

Please indicate the extent to which the employee can perform the following:
(C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

Lifting/carrying	**C**	**F**	**O**	**R**	**N**
5 lbs. or less					
5–10 lbs.					
11-20 lbs.					
21–40 lbs.					
41–60 lbs.					
61–100 lbs.					
100+ lbs.					
Activity					
Bend					
Squat					
Twist/turn					
Crawl					
Reach above shoulder					
Type/keyboard					
Joystick/ hand controls					
Vibration					

Pushing/pulling	**C**	**F**	**O**	**R**	**N**
5 lbs. or less					
5–10 lbs.					
11–20 lbs.					
21–40 lbs.					
41–60 lbs.					
61-100 lbs.					
100+ lbs.					
Driving					
Automatic drive					
Standard drive					

Upper extremities	**Yes**		**No**	
Simple grasping	☐ Right	☐ Left	☐ Right	☐ Left
Pushing/pulling	☐ Right	☐ Left	☐ Right	☐ Left

Operate foot controls	**Yes**		**No**	
	☐ Right	☐ Left	☐ Right	☐ Left
Simultaneous	☐ Yes		☐ No	

Comments

Physician name	Physician telephone
Date released with above restrictions	Date released for full-duty work
Projected date for MMI	Date and time of next appointment
Physician signature	Date

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

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

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

If the designated physician or 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, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

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

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment 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 1-717-783-5421.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND THE ABOVE RIGHTS AND DUTIES.

Employee name	Employee signature	Date
Supervisor name	Supervisor signature	Date

IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.

Supervisor name	Supervisor signature	Date

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NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of six or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.l)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least six providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties.
If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

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REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least six health care providers on the list, but there may be more than six listed.
2. At least three of the health care providers on the list must be physicians.
3. No more than four of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER

1-800-482-2383 (long-distance calls inside PA)
1-717-772-4447 (local and calls outside PA)

ACCIDENT INVESTIGATION

Every accident should be investigated thoroughly to determine the cause and put preventive measures in place. The investigation should be conducted as soon as possible to get the most accurate information, obtain the facts and prevent recurrence.

STEPS TO FOLLOW

1. ***Receive notification of incident***
2. ***Initiate the investigation***
    a. Secure the scene
    b. Form an investigative team (co-workers, maintenance, engineers, safety, etc.)
    c. Collect the facts
    d. Analyze the facts
3. ***Determine if reporting to authorities such as OSHA, CDC, etc. is required***
4. ***Complete required reports***
    a. Employee Incident Report
    b. Witness statement
    c. Include pictures
    d. Forward report
5. ***Identify***
    a. Root cause(s)
    b. Contributing factor(s)
    c. Corrective action(s)
6. ***Implement corrective action(s)***
    a. Immediate action(s)
    b. Short term
    c. Long term
7. ***Educate employee(s)***

THE QUESTIONS BELOW WILL ASSIST IN DETERMINING THE CAUSATION FACTORS OF THE ACCIDENT AND POSSIBLE CORRECTIVE ACTIONS.

QUESTIONS TO ASK	IF THE CAUSES APPEAR TO BE	
	CONDITIONS	ACTIONS
WHO	was responsible for it? can give me answers? should take corrective action?	is best qualified to do it? can give me answers? can show me what was being done?
WHAT	caused it to exist? caused it to be involved?	was its purpose? other way could it be done? details could be eliminated? instructions were not followed?
WHEN	did it occur? do similar conditions occur?	should it be done?
WHERE	was it? was its source? else does it exist? can I find out?	should it be done? else is it being done?
HOW	should it be corrected? can it be avoided in the future?	is the best way to do it? can it (job or detail) be improved?
WHY	did it exist? had no one noticed and corrected it?	was it being done? was it being done this way? was it (job or detail) necessary?

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