Eastern Alliance Insurance Group Claim Reporting Worksheet
24/7 Teleclaim: 1.800.336.3658 / Online: www.easternalliance.com
DO NOT FAX THIS FORM TO US

General Information

Date of loss/injury: _____ Submitter name and title: _____

Submitter phone #: (____) _____

Who is the contact person for the claim?: _____

First Report of Injury distribution:

If you want the First Report of Injury **emailed**, please provide an email address (you can provide up to 2):

_____ _____

If you want the First Report of Injury **faxed**, please provide a fax number (you can provide up to 2):

(____) _____ (____) _____

Policyholder Information

Employer mailing address: _____

County: _____

Physical address if different than mailing address: _____

County: _____

Location code/name where accident occurred: _____

Policy number: _____

Injured Worker Information

Injured Worker's Social Security Number: ____-____-_____

Injured Worker's name: _____

Injured Worker's mailing address: _____

Injured Worker's phone # with area code: (____) _____ Gender: _____ Marital status: _____

Birth date: ____/____/_____ # of dependents: _____

Hire date: ____/____/_____ State of hire: _____ Job title: _____

Employment status: _____ Was the injured worker paid full wages for the day of injury?: _____

Supervisor name and phone #: _____ (____) _____

Accident Information

Did the accident occur on the employer's premises?: _____

If no, provide the accident site's name/address:_____

Time of Injury: _____ Time shift began: _____

Did the injured worker lose time as a result of the injury?: _____

Date last work or # of days off: _____ First day off of work: _____

Has the injured worker returned to work (RTW)? _____ Date Returned: _____

If RTW, is the injured worker working with or without restrictions? _____

If working with restrictions: Will the injured worker lose any wages/hours/benefits?: _____

Please list any work restrictions: _____

_____

Date employer notified of the injury: _____ Name of person notified: _____

Did the injury result in death?: _____

Nature of injury: _____

Body part(s) injured: _____

If applicable: Right/Left/Both (circle one) Finger/Toes (which finger or toe): _____

Cause of injury: _____

Description of accident: _____

Were safeguards or safety equipment provided?: _____

Witness name and phone #: _____ (___) _____

Witness name and phone #: _____ (___) _____

Treatment Information

What type of initial treatment did the Injured Worker receive? _____

Was there emergency medical/ambulance service provided at time of loss? _____

Name, address, phone # of medical provider/facility: _____

_____ (___) _____

Physician name: _____

Follow-up treatment information: _____

_____

Was a list of medical providers (panel) given to the Injured Worker? _____

Additional Information

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Workers' Compensation is designed to provide wage loss benefits and payment for reasonable medical care for one who is injured on the job.

Remember: It is important to tell your employer about your injury immediately.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you must select. You must obtain treatment from one or more of these providers for ninety (90) days from the date of your first visit.

If you have a medical emergency, you may go to the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you seek treatment from a non-panel provider within the first ninety (90) days following your first visit, your employer will not have to pay for those services.

In the event invasive surgery is prescribed by a physician or other health care provider on your employer's panel, you are entitled to a second opinion from any other health care provider of your choice. If the opinion differs from the one provided by the panel provider, you may choose which course of treatment to follow. However, the second opinion must state a specific course of treatment. If you choose the treatment offered by the second opinion you must receive that treatment from a panel provider for a period of ninety (90) days from the date of the visit to the provider of the second opinion.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of services rendered if such services are determined to have been unreasonable or unnecessary. The non-panel provider must provide an initial report to the employer, within ten (10) days of the first treatment and every thirty (30) days thereafter, as long as the treatment continues.

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.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

☐ ***At Time of Hire*** ☐ ***After an Injury***

Employee Signature_____ Date_____

Witness Signature_____ Date_____

Blackhawk School District - Darlington (16115)
(7/9/2021)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.

2. In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers:

3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.

4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.

6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.

7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

PLEASE CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-855-572-3926 FOR ASSISTANCE IN SCHEDULING PHYSICAL/OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITIATION OR SEND THE REFERRAL FORM TO easternreferrals@medrisknet.com

Name	Address	Scheduling	Area of Specialty
Worksite Medical	510 Jamison St Ellwood City, PA 16117	724-716-6742	Occupational Medicine
UPMC Jameson WorkHealth	2008 W State St. New Castle, PA 16101	724-654-8719	Occupational Medicine
MedExpress Urgent Care PC	2652 Darlington Rd Beaver Falls, PA 15010	724-891-3278	Urgent Care
Lawrence County Orthopaedic & Sports Medicine-UPMC	3120 Wilmington Rd New Castle, PA 16105	724-658-5311	Orthopedics
Lawrence County Orthopaedic & Sports Medicine- Upm	291 State RT 288 Elwood City, PA 16105	724-658-5311	Orthopedics
Heritage Valley Medical Group Surgical Associates	93 Boundry Ln Bridgewater, PA 15009	724-773-6400	General Surgery
Tri State Neurosurgical Associates	12680 Perry Hwy Wexford, PA 15090	877-635-5234	Neurosurgery
Sewickley Eye Center	95 A Golfview Drive Rochester, PA 15074	724-770-9000	Ophthalmology
MedRisk PT/OT Network	Call Toll Free for Scheduling	1-855-572-3926	Physical and Occupational Therapy
MedRisk Chiro Network	Call Toll Free for Scheduling	1-855-572-3926	Chiropractic Care
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI
Carlisle Medical, Inc.	Call Toll Free for Closest Location	1-800-553-1783	DME
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	DME/Pharmacy
Homelink	Call Toll Free for Closest Location	1-800-571-2943	DME/Supplies

Blackhawk School District - Darlington (16115)
(7/9/2021)
NOTA A EMPLEADOS EN CASO DE LESIONES DE TRABAJO

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717)396-7095
(855)533-3444

1. Si sufre una lesión en el trabajo o su empleador o su compañía de seguros le deben pagar por servicios y suministros razonables quirúrgicos y médicos, aparatos y prótesis ortopédicos, inclusive la instruction en su uso.

2. Para asegurar que su tratamiento médicos sea pagado por su empleador o la compañía de seguros, ústed debe seleccionar uno de los proveedores de la lista abajo de esta página.

3. Debe de seguir consulatando a uno de los médicos de la lista que se encuentra abajo do este página si necesita tratamiento, por noventa (90) días de la fecha de su primera visita.

4. Si una de las personas de este lista le se refiere a otro especialista licenciado, su empleador o su asegurador pagarán las facturas para estos servicios.

5. Despues de los primeros noventa (90) días, si usted todavia necesita tratamiento y su empleador le ha proporcionado una lista como la que se encuentra abajo, ústed puede escoger ir a otro proveedor de la asistencia medica para el tratamiento. Debe notificar a su empleador de este acción dentro de cinco dias de su visita incial.

6. Si su médico de la lista le receta cirugía invasiva, ústed puede pedir una segunda opinión de cualquier otro médico. Si la opinión del otro médico difiere de la del médico de la lista ústed puede decidir que tipo de tratamiento desea recibir. Sin embargo, la segunda opinion deberá contener un plan de tratamiento especifico y detailedo. Si ústed elige la segunda opinión, los procedimientos de la segunda opinión deberan ser realizados por uno de los médicos de la lista por los primeros noventa (90) días. Por lo tanto, en este situación, el trabajador puede estar obligado a tratar con un proveedor designado por el empleador durante un máximo de 180 días

7. Si ústed se enfrenta a una emergencia médica, puede asegurar ayuda de un hospital, médicos, o de un proveedor de asistencia médica de su preferencia para su lesión de trabajo. Sin embargo, cuando la emergencia sea resuelta, ústed debe buscar tratamiento de un proveedor de la lista que se encuentra on este página.

POR FAVOR LLAMADA EASTERN ALLIANCE'S QUE PLANIFICA SERVICIOS TOCA LIBERTA EN 1-855-572-3926 PARA LA AYUDA A PLANIFICAR CON FISICO/REHABILITACION DE TERAPIA OCUPACIONAL O QUIROPRACTICA O ENVIAR LA REFERENCIA DE A easternreferrals@medrisknet.com

Nombre de Clínica	Dirección	Consultas	Area De Especialidad
Worksite Medical	510 Jamison St Ellwood City, PA 16117	724-716-6742	Occupational Medicine
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MedRisk PT/OT Network	El Peaje de la llamada Liberta Par Planificación	1-855-572-3926	Physical and Occupational Therapy
MedRisk Chiro Network	El Peaje de la llamada Liberta Par Planificación	1-855-572-3926	Chiropractic Care
One Call Care Management	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-872-2875	MRI
Carlisle Medical, Inc.	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-553-1783	DME
KeyScripts	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-866-446-2848	Pharmacy
Homelink	El Peaje de la llamada Liberta Par La Ubicación más Cercana	1-800-571-2943	DME/Supplies