MEMIC
Pennsylvania

NOTICE TO ALL EMPLOYEES

If you sustain a compensable accident while at work, your employer has arranged for the payment of your medical care with your insurance payor. It is your responsibility to immediately report the injury to your supervisor.

IN CASE OF INJURY

Employer.An injured employee must select a treating provider from the employer's properly posted listing of medical providers. Treatment with this provider shall be for (90) days from the date of the first visit for the work related injury or illness. Injured employees may choose another provider of their choice, or select from the employer/insurer's list after the first (90) days of treatment.Emergency medical care does not require preapproval and should be secured at the nearest location. The employer may not direct the employee to any specific provider on the list.The employee may switch from one designated provider to another designated provider.If a particular specialty is not on the list and the specialty is reasonable and necessary for treatment of the work injury, the employee will be allowed to treat with a health care provider of his or her choosing.Employers that establish a Coordinated Care Organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the act and appropriate flexibility to workers in selecting providers.Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers.

If you suffer a work-related injury, your insurance payor will pay for reasonable and necessary surgical, and medical services, medication, supplies, orthopedic appliances and prosthesis, including training in their use. In order to ensure that your medical treatment will be paid for by your insurance payor, you may select from one of the medical providers listed below. If the injury is a medical emergency, ensure that the injured employee is transported to the nearest emergency treatment facility. If you need assistance making an appointment for medical treatment, you may search for additional network providers at www.corvel.com/ppo-lookup/ or by calling 888-667-8435. Your Panel of Physician is attached hereto. Please speak with your supervisor now if you have any questions.

MEMIC CORVEL

WILKES-BARRE AREA SCHOOL DISTRICT
730 S MAIN ST
WILKES BARRE, PA 18702

Specialty	Name	Address	City	State	Zip	Phone
Occupational Medicine	Concentra Medical Centers	268 Highland Park Blvd	Wilkes Barre	PA	18702	(570) 822-8831
Urgent Care Center	MedExpress Urgent Care	677 Kidder Street	Wilkes Barre	PA	18702	(570) 825-2046
Orthopedic Surgery	Falvello, Anthony C	237 S MOUNTAIN BLVD	Mountain Top	PA	18707	(570) 861-8710
General Surgery	Martinez, Michael F	255 Delaware Ave	Wilkes Barre	PA	18701	(484) 426-2222
Neurology	Garg, Sanjeev	670 S River St Ste 203	Plains	PA	18705	(570) 552-7110
Ophthalmology	Boland, Thomas S	190 Welles St Ste 206	Forty Fort	PA	18704	(570) 718-0590
Diagnostic, PT/OT, DME, & Translation & Transportation	**Schedule through CareIQ, CorVel's Ancillary Network**					**866-866-1101**
	For Pharmacy Questions please call (800) 563-8438					
	If you need assistance finding an appropriate provider, please contact your workers' compensation carrier, MEMIC, at 800-660-1306, to speak with your claims specialist.					
	CorVel has made every effort to ensure the accuracy of this listing. However, changes may occur daily. We recommend you confirm with the healthcare provider, prior to receiving services, that he/she is currently participating with CorVel or one of CorVel's affiliate networks.					

2/22/2024

Pennsylvania Provider Panels
Instructions for Posting and Distribution

POSTING: Posting Notice and Panel of Physicians must be posted in a conspicuous area.

DISTRIBUTING PROVIDER PANELS:

To be completed immediately in order to start process of using the provider panels:

- All Associates must sign the Right and Duties and be provided with a copy of the panel.
- Associates signing of the Right and Duties must be witnessed and the witness (supervisor/HR) must sign at "Employer Representative"
- Signed Rights and Duties must be placed in Associate's personnel file
- If an Associate refuses to sign the Rights and Duties, the witness shall write "refused to sign" where the Associate should have signed and then sign as Employer Representative

To be completed at the Time of Injury:

- All Associates must sign the Right and Duties and be provided with a copy of the panel at the time an injury is reported
- Associates signing of the Right and Duties must be witnessed and the witness (supervisor/HR) must sign at "Employer Representative"
- Signed Rights and Duties must be placed in Associate' s personnel file
- If an Associate refuses to sign the Rights and Duties, tbe witness shall write "refused to sign" where the Associate should have signed and then sign as the Employer Representative
- If the nature of the Injury does not allow the Associate to sign the Right and Duties at the time of injury reporting, the Rights and Duties should be signed and panel provided within a reasonable amount of time after the injury.

To be completed for New Hire:

- All New Hires must sign the Rights and Duties and be provided with a copy of the panel
- Associates signing of the Right and Duties must be witnessed and the witness (supervisor/HR) must sign at "Employer Representative"
- If an Associate refuses to sign the Rights and Duties, the witness shall write "refused to sign" where the Associate should have signed and then sign as the witness
- Signed Right and Duties shall be placed in the Associate's personnel file

CORVEL

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 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 your review. Also, you may get a copy of this from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f. 1)(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 6 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 (circle one):

TIME OF HIRE WHEN I WAS INJURED OTHER

EMPLOYEE: _____ DATE _____

EMPLOYER REPRESENTATIVE: _____ DATE _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (MONTH / DAY / YEAR)

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY | PHONE NUMBER

EMPLOYEE: MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐

NUMBER OF DEPENDENTS

DATE OF BIRTH (MONTH / DAY / YEAR)

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS

FT = Full-time PT = Part-time SL = Seasonal VO = Volunteer ZZ = Other

EMPLOYER: WILKES-BARRE AREA SCHOOL DIST

STREET ADDRESS: 730 SOUTH MAIN STREET

CITY: WILKES-BARRE | STATE: PA | ZIP CODE: 18711-1

SIC CODE | EMPLOYER FEIN | PHONE NUMBER

COUNTY | NAICS CODE

FULL PAY FOR DAY OF INJURY? YES ☐ NO ☐

TIME EMPLOYEE BEGAN WORK AM ☐ PM ☐

TIME OF OCCURRENCE AM ☐ PM ☐

344 1197-1

LAST DAY WORKED (MONTH / DAY / YEAR)

DATE DISABILITY BEGAN (MONTH / DAY / YEAR)

DATE EMPLOYER NOTIFIED (MONTH / DAY / YEAR)

DATE RETURNED TO WORK (MONTH / DAY / YEAR)

DATE OF HIRE (MONTH / DAY / YEAR)

CONTACT FIRST NAME | CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

LIBC 344

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

H

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

6 1 0 3 8 0 0 3 9 8

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME: MEMIC INDEMNITY COMPANY
STREET PO BOX 3606
CITY PORTLAND STATE ME ZIP 04104
BUREAU CODE: FEIN:

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

MEMIC

CORVEL

Injured Worker's
First Fill Prescription Form

Injured Worker's Name: _____

Date of Injury: _____

Injured Worker's Instructions

On your first Pharmacy visit, please give this notice to your pharmacist. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **MEMIC.** 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 most medications. Please note: You will need to provide your Social Security number (SSN #) to the pharmacy in order to process your prescriptions.

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 with processing claims, please contact the CorVel Pharmacy Department at **(800) 563-8438.**

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:	**RXFFWC8757788**
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 62,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	Hannaford Pharmacy	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	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