

# How to respond to a workplace injury:

- For life-threatening medical emergencies, call **911**.
- For non-life-threatening injuries, call the **24/7 Nurse Line at (844) 581-0828** to report the incident and get your employee the right care.

**REMEMBER: IT IS IMPORTANT  
TO TELL YOUR EMPLOYER  
ABOUT YOUR INJURY**

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

**Employer Name:** \_\_\_\_\_ **Date Posted:** \_\_\_\_\_

**IF INSURED:**  
(Complete all applicable spaces)

**IF SOMEONE OTHER THAN INSURER IS  
HANDLING CLAIMS:**  
(Complete all applicable spaces)

Name of Insurance Company: Pie Insurance Services  
MGA for Sirius America

Name of TPA (Claims administrator): \_\_\_\_\_  
CorVel Corporation

Address: 1615 L St NW, Ste 620  
Washington DC 20036

Address: 661 Andersen Drive Suite 450, Foster Plaza 7,  
Pittsburgh, PA 15220

Telephone Number: 855-705-2716

Telephone Number: 855-275-9871

Insurer Code: A.M. Best #: 002642 NAIC #: 38776

**IF SELF-INSURED**  
(Complete all applicable spaces)

**IF SOMEONE OTHER THAN SELF-INSURER IS  
HANDLING CLAIMS:**  
(Complete all applicable spaces)

Name of person handling claims at  
the self-insured: \_\_\_\_\_  
\_\_\_\_\_

Name of TPA (Claims administrator):  
\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Insurer Code: \_\_\_\_\_

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

**Employer Information  
Services**  
717.772.3702

**Claims Information Services**  
toll-free inside PA: 800.482.2383  
local & outside PA: 717.772.4447

**Hearing Impaired**  
PA Relay 7-1-1

**Email**  
ra-li-bwc-helpline@pa.gov



*Auxiliary aids and services are available upon request to individuals with disabilities.  
Equal Opportunity Employer/Program*



# Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act Section 306 (f.1)(1)(i)

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

## Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

- 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.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) 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.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**If you have any questions, ask your human resources office or  
call the Bureau of Workers' Compensation at 800.482.2383**

**Text of Section 306 (f.1)(1)(i):** The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

## Workers' Compensation Information

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](http://www.state.pa.us), PA Keyword: workers comp.

I hereby acknowledge receipt of the "Workers' Compensation Information" form.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Supervisor Name

Date: \_\_\_\_\_