Highview
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WORKERS COMPENSATION

WELCOME PACKAGE AND CLAIM KIT

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Dear Policyholder:

Thank you for placing your workers' compensation coverage with Highview National Insurance Company (HNIC). We look forward to providing you with superior customer service and compassionate care for your injured workers.

Enclosed you will find important information and instructions regarding workers' compensation requirements and the claims process. **Please read and follow all instructions contained herein to ensure compliance, avoid penalties, and mitigate the cost of any claims.**

Please follow the instructions at the end of this letter for proper posting of the **LIBC-500 Notification**, and **Medical Treatment Provider Poster**. Also included are your **HNIC 24/7 Work Injury Nurse and Telehealth Line posters** which should also be posted in one or more conspicuous places at each business location.

This packet includes documentation necessary for the processing and administration of a claim in the event of a workplace injury. Please use these documents to collect all information regarding the claim and send them when reporting a claim and/or upon request. The assigned claims professional will forward necessary documentation to the appropriate state entity.

To mitigate the cost of claims, it is critical that you *thoroughly* and *immediately* investigate, document, and report all workplace injuries *within 24 hours of the incident*.

For fastest claims processing, please use our online reporting tool:

- Login to your account at www.highviewins.com
- Click Incidents, then New Incident to enter the claim
- After entering all requested information, upload all forms and claim related documents including the employee incident report, supervisor's report, any witness statements, and Form IA-1
- Make sure to hit submit when you have completed the incident entry

Claims can also be reported via fax at **845-335-4667** or via email at **claims@highviewins.com**.

Pennsylvania state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within 5 days of employer knowledge of injury.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury of illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of "medical control" and a significant increase in the potential claim cost.

In addition, you must notify Highview immediately, if the employee loses time from work at any point during the claim, either initially following the injury or at any point thereafter.

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

If an employee has a severe injury and needs immediate medical assistance, please call 911. If an employee needs treatment for any work related injury, please have them call 833-281-0215 to speak with a nurse. The nurse will assist by arranging a telehealth or onsite physician appointment, as appropriate.

Please provide all injured workers with the following documents upon notice of injury:

- First Fill Letter for Pharmacy Benefits
- *To Be Completed and Returned to HNIC*
  - Employee Incident Report
  - Notice of Workers' Compensation Information
  - Notice of Employee's Rights and Duties
  - Medical Provider Panel Poster
  - Treating Physician Designation Form
  - HNIC – Release of Information

If employee needs treatment, please also provide them with:

- First Aid Treatment Authorization
- Work Assessment Form

If an injured worker is placed out of work or has their work duties restricted by the treating physician, they should be required to provide a completed work assessment form following each doctor's visit. These forms should be sent to claims@highviewins.com or the adjuster upon receipt. Restricted duty should be transitional and provide a path for the injured employee's return to a full duty capacity. All efforts should be made to have an injured worker return to work as soon as possible following an injury. When an employee loses time from work due to a workers' compensation injury, the cost of the claim increases exponentially. Furthermore, with every day they remain out of work, their chances of ever returning drop dramatically. If you need assistance making suitable accommodations to accommodate the return of an employee with physical restrictions, please reach out to the claims adjuster or HNIC.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact us via phone at **(845) 363-0500** or via email at **claims@highviewins.com**. Questions regarding your insurance policy or coverage should be directed to your broker or representative.

Please remember: to mitigate the cost of your claims, complete and return all forms to the best of your knowledge, provide as much information and documentation as you can regarding the claim or any related event, and cooperate fully with HNIC staff and your claims adjuster in a timely manner for the duration of the claim.

THE LEAST EXPENSIVE CLAIM IS ALWAYS THE PREVENTED CLAIM

For assistance on enhancing your safety and loss control processes, please contact Highview National Insurance Company today at 845-363-0500 or via email at info@highviewins.com.

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info@highviewins.com / 845.363.0500 / highviewins.com

WORKERS' COMPENSATION POSTING REQUIREMENTS

Form LIBC-500 - Workers' Compensation Insurance Posting:

- Post in one or more conspicuous places readily accessible to all employees at all business locations and work sites
- Must be posted in the areas used for the treatment or administration of first aid to injured employees
- Must contain the insurer/carrier contact information
- Print on 8.5" x 11" paper
- Text must be in at least 11-point font-size

To complete the form, please enter the following information in the spaces provided:

- Your company name
- Date posted
- Name of your designated insurance company
- The Bureau Code assigned to your designated insurance company

The Bureau publishes a listing Bureau Codes assigned to authorized insurers at: https://www.dli.pa.gov/Businesses/Compensation/WC/insurance/Pages/Insurance-Carrier-Codes-G-L.aspx

For your convenience, our other contact information has been entered on the Poster. Please note, the form fields are designed to populate text meeting the statutory font-size requirement.

(Pennsylvania Workers' Compensation Act § 305(e))

Requirements for Workers' Compensation Information Document:

- Must be provided to all employees:
  - At the time of hire
  - Immediately after a work accident or injury or as soon as possible thereafter
- Print on 8.5" x 11" paper
- Text must be in at least 11-point font-size

Please note, the text of this document meets the statutory font-size requirement.

(34 Pennsylvania Administrative Code § 121.3b)

To complete the form, please enter the following information in the spaces provided:

- Location Name
- Name of an employer representative to provide copies of panel list
- Physician and provider contacts including: physician name, specialty, clinic name, address, and phone

(34 Pennsylvania Administrative Code § 127.754)

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, PA Keyword: workers comp

I have read this document and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this acknowledgment upon my request.

Employee Name

Employee Signature

Date

34 Pa. Code § 121.3b

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

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)

Name of Insurance Company: Highview National Insurance Company

Address: 1 Alpine Ct. Suite 102
Spring Valley, NY 10977

Telephone Number: (845) 363-0500

Insurer Code: 2630

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

Name of TPA (Claims administrator): Claimsake

Address: PO Box 448
Monsey, NY 10952

Telephone Number: (845) 751-7253

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

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

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

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

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN 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 THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

WORKERS' COMPENSATION EMPLOYEE INCIDENT REPORT

To Be Completed by the Injured Employee Only

Name of Employer: _____ Date of Injury: _____

Claimant Information

Full Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Injury Details

Time of Injury: _____AM / PM Time Your Shift Began on the Date of Injury: _____ AM / PM

What were you doing at the time you were injured: _____

Describe in **detail** how your injury happened: _____

_____

_____

List All Body sites Injured: _____

Were there any witnesses? ☐ Yes ☐ No Name(s) of witness: _____

When did you report the injury to your employer? _____ To whom? _____

What were you advised to do? _____

Cause of Injury – Check All That Apply:

☐ Abrasion/ Cut/ Puncture	☐ Resident Handling	☐ Malfunctioning Equipment
☐ Slip/Trip/Fall	☐ Resident Behavior	☐ Physical Hazard
☐ Object in Eye	☐ Burn	☐ Improper Ergonomics
☐ Needle Stick/ Blood Exposure	☐ Failure to use appropriate PPE (personal protective equipment)	☐ Other: _____ _____

What acts, failure to act, and/or conditions contributed most directly to this accident:

_____

What corrective actions were taken or planned to prevent future accidents:

_____

Were you employed with another employer at the time of your injury? ☐ Yes ☐ No

Name of employer: _____ Address: _____

Phone: _____ Supervisor: _____ Job title: _____ Duties: _____

Medical Treatment

Initial Medical Treatment: ☐ None Required ☐ Minor by Employer ☐ Minor Clinic/Hospital

☐ Emergency Care ☐ Hospitalized for More than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Are you currently out of work due to your injury? ☐ Yes ☐ No Date Disability Began:_____

Next Scheduled Shift after Incident: _____ Date Returned to Work: _____

Past Medical History

Please list any medical illnesses/conditions: (i.e. heart disease, diabetes, hypertension, asthma, etc.)

_____

Who is your treating doctor? _____ Phone number: _____

Are you currently taking any medications? ☐ Yes ☐ No Names of medications:_____

Have you ever had ANY prior injuries? ☐ Yes ☐ No If yes, please give date(s) _____

Body sites previously injured: _____

Have you ever been hospitalized? ☐ Yes ☐ No Reason for hospitalization: _____

I certify under the penalties of perjury that all statements made in this claim are true, correct, and complete to the best of my knowledge, information, and belief, and that I did not suppress or withhold evidence necessary to settle this claim. I understand that any employee who willfully and knowingly files a false workers' compensation claim or misrepresents the circumstances of their injury in order to obtain benefits will be guilty of a felony and will be prosecuted to the fullest extent of the law.

Printed Name: _____ Signature: _____ Date: _____

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Supervisor's Report of Employee Accident

Employee Name	
Employer Name	

Date of Accident	
Time of Accident	
Date Accident Reported	

Did the employee report the accident immediately?	YES	NO
Location of Accident *(specify if off-site address)*		

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the accident occurred (including self)?

Do you have any reason to question the legitimacy of the accident? If so, please explain:

Any other info to share?

The above report is true and correct:

Prepared by:	Title:	Date prepared:

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Witness' Report/Statement of Employee Accident

Employee Name	
Witness Name, Title, & Phone	
Witness Address	

Date of Accident	
Time of Accident	
Location of Accident (specify if off-site address)	

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

I certify that the above statement is accurate and complete to the best of my knowledge

Witness Signature: _____ Date: _____

If not completed by person given statement, Interviewer Name: _____

Interviewer Signature: _____

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an Insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or CONCEALS any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

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Accident Investvation

Accident Investigation → Root Cause Determination → Correction Actions

The goal of accident investigation is to determine the root cause of an event in order to implement corrective measures to prevent recurrence of similar accidents.

The **ROOT CAUSE** is the initiating event in the sequence of events leading to the accident that if removed, would have prevented it from happening. The root cause is **NOT** the direct cause of the accident. Root causes are often confused with surface causes, which are symptoms of the root cause and are discovered along the way to determining the root cause.

HOW DO YOU KNOW IF YOU HAVE REACHED THE ROOT CAUSE?

It is helpful to establish an event chain, beginning with the direct cause and working your way through the symptoms until the root cause is determined. If you can still ask 'why', you have likely not yet reached the root cause. The reporting form provides a listing of root causes to select from.

ACCIDENT INVESTIGATION EXAMPLE (WITH EVENT CHAINS):

An employee slips and falls due to water collecting on the floor from a leaking pipe, which could have been discovered and fixed had someone inspected the facility for hazards. If there are no procedures in place to ensure regular inspections, "no inspection procedures" is the root cause of this accident and the accident investigation chain is as follows:

Slip/Trip/Fall	Wet Floor	Leaking Pipe	Failure to Inspect	NO INSPECTION PROCEDURES
(Direct Cause)	*(Symptom)*	*(Symptom)*	*(Symptom)*	*(Root Cause)*

If instead, someone was supposed to conduct an inspection, but did not, "procedures not followed" is the root cause and the accident investigation chain is as follows:

Slip/Trip/Fall	Wet Floor	Leaking Pipe	Failure to Inspect	PRODCEDURES NOT FOLLOWED
(Direct Cause)	*(Symptom)*	*(Symptom)*	*(Symptom)*	*(Root Cause)*

Finally, if CORRECTIVE ACTION(S) have not been executed, the accident investigation process is not complete. Incidents should be reviewed with all department employees to assist in avoiding the same accident re-occurring with a different employee, as should any resulting corrective action policies/procedures. While re-trainings on existing procedures may sometimes be a necessary and important loss control response, on their own they are the least effective corrective action method. Physical and procedural controls, such as footwear requirements, machine guards, re-assigning a caregiver to no longer work with a specific combative resident, observing the employee to confirm correct practices are being followed, and establishing accountability and disciplinary procedures (discipline not necessarily for the injured employee, but for the employee who failed to adhere to the policy in question) are far more effective and should be implemented whenever possible.

APPLYING TRAINING AND PHYSICAL /PROCEDURAL CONTROLS FOR EACH ROOT CAUSE IDENTIFIED IS BEST PRACTICE.

HNIC will provide guidance, as needed, on each claim submission to ensure the root cause is discovered and appropriate corrective action(s) implemented in response to both the symptoms and the root cause. The form itself is designed to guide you to provide this necessary information.

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Root Cause Analysis & Corrective Action Response

Are there specific procedures in place relating to this incident? ☐ Yes ☐ No

- **If YES, procedures are in place:**
- Who is responsible/accountable for compliance with the procedures? _____
  - ☐ Were the procedures followed? ☐ Yes ☐ No
    - **If NO, procedures were not followed:**
    - Was there training provided on the procedures? ☐ Yes ☐ No
      - ☐ **If YES, training was provided:**
      - ☐ How often? _____
      - ☐ When was it last administered to the employee(s) involved?
    - Is there a discipline/corrective action policy for failure to follow the procedures? _____ ☐ Yes ☐ No
      - ☐ **If YES, there is a discipline policy:**
      - ☐ Please describe:_____
      - ☐ Was it applied to the employee(s) identified above as responsible/accountable for compliance? ☐ Yes ☐ No

Root Cause Determination

- ☐ **NO INSPECTION PROCEDURES**
- ☐ **GAP IN INSPECTION PROCEDURES**
- ☐ **INSPECTION PROCEDURES NOT FOLLOWED**
- ☐ **NO SAFE PATIENT HANDLING PROCEDURES**
- ☐ **GAP IN SAFE PATIENT HANDLING PROCEDURES SAFE PATIENT**
- ☐ **HANDLING PROCEDURES NOT FOLLOWED**
- ☐ **COMBATIVE RESIDENT BEHAVIOR - NO IDENTIFIED TRIGGER**
- ☐ **COMBATIVE RESIDENT BEHAVIOR - IDENTIFIED TRIGGER**
  PLEASE DESCRIBE IDENTIFIED TRIGGER HERE
- ☐ **NO DE-ESCALATION PROCEDURES DE-ESCALATION**
- ☐ **PROCEDURES NOT FOLLOWED**
- ☐ **NO APPLICABLE PPE/FOOTWEAR REQUIREMENTS**
- ☐ **REQUIRED PPE/FOOTWEAR NOT WORN**
- ☐ **NO RESIDENT SPECIFIC CARE PLAN IN PLACE**
- ☐ **GAP IN RESIDENT SPECIFIC CARE PLAN**
- ☐ **RESIDENT SPECIFIC CARE PLAN NOT FOLLOWED**
- ☐ **NO APPLICABLE POLICIES/PROCEDURES**
  PLEASE DESCRIBE APPLICABLE PROCEDURES
- ☐ **GAP IN APPLICABLE POLICIES/PROCEDURES**
  PLEASE DESCRIBE APPLICABLE PROCEDURES
- ☐ **APPLICABLE POLICIES/PROCEDURES NOT FOLLOWED**
  PLEASE DESCRIBE APPLICABLE PROCEDURES

Root Cause Corrective Actions

- ☐ **REVIEWED PROPER PROCEDURES WITH EMPLOYEE ENSURED EMPLOYEE'S UNDERSTANDING**
- ☐ **OBSERVED EMPLOYEE PERFORMING PROCEDURE(S) PROPERLY**
- ☐ **REVIEWED INCIDENT WITH ALL DEPARTMENT EMPLOYEES EMPLOYEE**
- ☐ **DISCIPLINED FOR DISREGARDING PROCEDURES**
- ☐ **ACCOUNTABILITY/RESPONSIBILITY/RISK OWNER ASSIGNED**
  PLEASE PROVIDE NAME AND JOB TITLE OF ACCOUNTABLE PARTY HERE:
- ☐ **ESTABLISHED INCENTIVE PROGRAM TO ENCOURAGE COMPLIANCE WITH PROCEDURES**
- ☐ **ESTABLISHED TRAINING(S)**
- ☐ **INCREASED TRAINING FREQUENCY**
- ☐ **NOTED RESIDENT'S CARE PLAN**
- ☐ **ADJUSTED OR EXPANDED EXISTING PROCEDURES**
  PLEASE DESCRIBE 'ADJUSTED OR EXPANDED EXISTING PROCEDURES' HERE:
- ☐ **ESTABLISHED NEW PROCEDURES**
  PLEASE DESCRIBE 'NEW PROCEDURES' HERE
- ☐ **OTHER**
  PLEASE DESCRIBE 'OTHER' HERE

THE ABOVE REPORT IS TRUE AND CORRECT

PREPARED BY:	TITLE:	DATE PREPARED:

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Highview
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First Aid Treatment Authorization

(Employee Copy)

Date:

Employee:

Job Title:

Claim Number:

Injury Date:

Employer:

The above, noted employee, _____

requests medical treatment at your clinic/hospital for injury to the following body part[s]

_____.

THIS WILL SERVE AS AUTHORIZATION FOR INITIAL EVALUATION AND TREATMENT AND WILL BE PAID IN ACCORDANCE WITH THE PENNSYLVANIA WORKERS' COMPENSATION FEE SCHEDULE.

If the employee can return to work without restrictions, please give the employee a full duty release note.

The employer may offer temporary transitional duty and may be able to accommodate medical work restrictions. If it's your medical opinion that the employee is unable to return to work to full duty, please complete the attached *Work Assessment Form.*

Paper Bill Submission:
Highview National Insurance Company
PO Box 2936
Clinton IA 52733

Fax Line: +1(845) 422-9994

Electronic Bill Submissions:
Payer ID: J4588
Clearinghouse: Jopari Solutions

Provider Inquiries / Provider Contact Center (Client Dedicated Line): (877) 547-9955

WORKERS' COMPENSATION FRAUD STATEMENT: Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT, or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Work Assessment Form

To Be Completed by the Treating Physician

Claimant: _____ SSN/ID: _____

Date of Injury: _____ Date of evaluation: _____

Diagnosis/ condition (brief explanation): _____

Is the injury or illness causally related to the worker's employment? ☐ Yes ☐ No

What is the *current* percentage (0-100%) of temporary disability? _____

Evidence of preexisting condition? ☐ Yes ☐ No If yes, please explain: _____

_____

Anticipated date of discharge from your care OR anticipated date of MMI: _____

Please outline your current treatment plan:

_____

_____

Anticipated RTW Light Duty: _____ Anticipated RTW Full Duty: _____

Based on my assessment and treatment of this injury, I recommend:

- Can the employee work an 8-hour day? ☐ Yes ☐ No If no, how many hours / day? _____
- In an 8-hour day, employee can: (circle full capacity for each)

Sit	1	2	3	4	5	6	7	8	Hours/ day
Stand	1	2	3	4	5	6	7	8	Hours/ day
Walk	1	2	3	4	5	6	7	8	Hours/ day

- Employee can lift / carry: (Please check as appropriate)

	Not at this time		Occasionally		Frequently		No Restriction	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
0-10 lb.	☐	☐	☐	☐	☐	☐	☐	☐
11-25 lb.	☐	☐	☐	☐	☐	☐	☐	☐
26-50 lb.	☐	☐	☐	☐	☐	☐	☐	☐
51-100 lb.	☐	☐	☐	☐	☐	☐	☐	☐
100+	☐	☐	☐	☐	☐	☐	☐	☐

- Employee is able to: (please check all that apply)

	Not at this time	Occasionally	Frequently	No Restriction
	0%	1-33%	34-66%	67-100%
Balance	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Use Foot	☐	☐	☐	☐

- Employee can use upper extremities for repetitive: (check as appropriate)

Simple Grasp	Firm Grasp	Fine Manipulation	Pushing / Pulling	(Circle Appropriate)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left

- Employee can use lower extremities for repetitive movement such as foot controls:
  Right ☐ Yes ☐ No Left ☐ Yes ☐ No

Can the employee drive or independently use public transportation? ☐ Yes ☐ No

Employee is released to work as of: ___/___/_____ ☐ With ☐ Without restrictions noted above.

Date of next evaluation: ___/___/_____

Medical Provider's Signature: _____ Date: ___/___/_____

Print Provider's Name: _____ Provider's Phone Number: (_____) _____- _____

Highview
A Muller Company

CLINICALCARE24

Injured at Work?
Report your injury to your supervisor
Then call the Nurse Triage line at

833-281-0215

Nurse Triage Service Available 24/7/365

IF IT'S AN EMERGENCY, CALL 911

Mitchell ScriptAdvisor

FAST & SIMPLE: GETTING YOUR FIRST PRESCRIPTION FILLED

Mitchell ScriptAdvisor has been selected by **Highview National Insurance Company** to assist you in obtaining prescription drugs related to your claim. This form enables you to fill prescriptions written by your authorized 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.

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 https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx 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:	023377
PCN:	MPS
Group:	001806TC

Questions? Need Help?

Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

This card is to be used for prescriptions related to your injury covered under your 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

866.846.9279

Mitchell ScriptAdvisor

RÁPIDO Y SIMPLE: OBTENER SU PRIMERA RECETA SURTIDA

Mitchell ScriptAdvisor ha sido seleccionado por **Highview National Insurance Company** para ayudarlo a obtener medicamentos recetados relacionados con su reclamo. Este formulario le permite surtir recetas escritas por su médico autorizado medicamentos relacionados con su lesión. Simplemente preséntelo en la farmacia en el momento en que se surta su receta. Este formulario debe garantizar que NO tendrá gastos de bolsillo.

Tenga en cuenta: Esta es una tarjeta de prescripción temporal; es posible que reciba una tarjeta de medicamentos permanente en el futuro.

Para su comodidad, **Mitchell ScriptAdvisor** tiene una extensa red de farmacias minoristas, incluidas las principales cadenas de farmacias. Para ubicaciones de farmacias, puede llamar a nuestro número gratuito al 866.846.9279 o visitar nuestro sitio web en https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx para acceder al localizador de farmacias.

Empleado

- **Puede comunicarse con el Servicio al Cliente de Mitchell al 866.846.9279 o puede presentar esta hoja al farmacéutico junto con su receta.**

Farmacia

- Esta hoja es una tarjeta de identificación de prescripción temporal para un suministro de **10** días hasta que se pueda proporcionar la tarjeta permanente de esta persona.
- **Cree el número de identificación** basado en los criterios proporcionados y escríbalo, junto con el nombre del individuo, en la tarjeta de identificación a continuación.
- Todos los datos necesarios para procesar este script a través del Sistema de Adjudicación de Script Care se incluyen en la tarjeta de medicamentos que se representa a continuación.

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:	023377
PCN:	MPS
Group:	001806TC

Preguntas? Necesita Ayuda?

Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

Esta tarjeta debe usarse para medicamentos recetados relacionados con su lesión cubierta por la póliza de seguro. El uso de esta tarjeta no renuncia a ninguna limitación o exclusión de la póliza. Esta tarjeta no confirma la cobertura. Para confirmar la elegibilidad u obtener información específica, comuníquese con la mesa de ayuda con la información que se encuentra en el anverso de esta tarjeta.

mitchell
AN ENLYTE COMPANY

Mitchell International
866.846.9279

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification 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. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: 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 your employer is not liable for the medical bills incurred.

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 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 that they are explained above.

_____ _____

Print Name Employee Signature Date

See reverse for a complete text of Section 306 (f.1)(1)(i)

If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

PENNSYLVANIA WORKERS' COMPENSATION ACT
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.

REQUIREMENT FOR EMPLOYER'S
LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.

2. At least 3 of the health care providers on the list must be physicians.

3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).

4. The names,addresses, phone numbersand areas of medical specialties of all health care providersmust 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 medical 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

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

Pennsylvania Medical Provider Panels

Treating physicians can have a significant impact on a claim's medical cost. A key component to controlling these costs and reaching a satisfactory resolution of a claim for all parties involved is ensuring that the claimant receives quality medical care from a competent physician. In the state of Pennsylvania, employers have a single option, in the form of provider panels, for asserting some influence on the selection of the treating physician. Pursuant to PA WC Act § 306(f.1) and 34 Pa. Code § 127.751(a), excluding denied claims and emergencies, the establishment and maintenance of a valid medical provider panel may limit an injured worker's initial physician choice to medical providers designated within the panel for the first 90 days of treatment. The first 90 days of a claim is a crucial period in the life of a claim which may set the tone for the remaining days of a claim. Please note, the failure to authorize initial medical treatment upon notice of an employee's work injury may result in a waiver of panel rights.

This document contains a summary of the essential elements for the creation and maintenance of an enforceable medical provider panel.

MEDICAL PROVIDER PANEL REQUIREMENTS

- **Notice to Workers** – The law requires employers to provide notice of their medical provider panel to all employees.Notice should be given prior to and upon knowledge of an employee's work injury.
  - **Posting:** Employers are required to post the panel listing in prominent and readily accessible places at all business locations and work sites. Each panel must include required notices contained within 34 Pa. Code § 127.755(b). Our Medical Provider Panels Poster may be used to comply with the requirements.
    - Print on legal sized paper (8.5" x 14")
    - Must be posted in the areas used for the treatment or administration of first aid to injured employees
  - **Acknowledgement Form:** The use of an acknowledgement form to be signed by all employees to show that they have been notified of the panel and its use is also required. **Employees must receive the acknowledgement form at the time of hire and upon notice of accident or injury.** Our Medical Provider Panels Poster contains an area to obtain an employee's signature and acknowledgement.

- **Number of Providers** – A panel must include a minimum of at least 6 health care providers within a reasonable distance.
  - No more than 4 providers may be affiliated or within a coordinated care organization.
    - Coordinated care organizations only count as one of the provider choices
  - Physicians and providers that are employed by, owned, or controlled by the employer may not be used unless such employment, ownership, or control is disclosed.
  - At least 3 physicians must be included
    - Specialty Recommendations: orthopedics, neurology, general surgeon, occupational medicine, and ophthalmology.

PANEL PERIOD

- In general, a valid and enforceable panel restricts a claimant's provider choice to one or more health care providers within a panel for up to 90 days from the of the first visit for the treatment of the work injury or illness.

PANEL MAINTENANCE

- To guarantee panel validity over time, routine maintenance is recommended.
  - Every six months to a year, each physician or provider on a panel should be contacted to confirm that their contact information is up-to-date and that they are still accepting and treating workers' compensation patients.

PHYSICIAN SELECTION AND CHANGES

- Excluding denied claims and emergencies, an injured worker is required to select the authorized treating physician from the panel list.
  - Obtain the injured worker's initialselection in writing.Our Treating Physician Designation Form may be used for this purpose.
  - Please note, exceptions may apply if a physician prescribes a surgical procedure. Pleaserefer to the Medical Provider Panels Poster document for more information.
- Injured workers have the right to change to another provider listed on the panel without prior approval.

CLAIM PROCEDURES

- All work accidents and injuries must be reported to us as soon as possible so that we are able to begin the claim investigation promptly. Please have the injured worker complete our Pennsylvania Employee Accident Report.
- When reporting the claim, please make sure to provide a copy of your posted physician panel and a copy of the injured worker's signed panel acknowledgment. This allows the Claims Professional to enforce panel use.

For assistance with selecting providers to use for your Medical Provider Panel, please email us at claims@highviewins.com

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Highview
A Muller Company

Treating Physician Designation

By signing this document, I acknowledge my employer's posted physician panel. I understand that I must select a medical provider from the panel list to provide medical care for my work injury for the first 90 days of treatment. I also understand that my employer may not be required to pay for any medical treatment that I obtain from a medical provider that is not included on the panel.

I further understand that, if I am not satisfied with the first physician that I select from the panel, I have the right to change to another physician listed on the same panel.

INITIAL TREATING PHYSICIAN SELECTION: I hereby select the following physician to provide medical services and treatment for my work injury or illness:

NAME	
FACILITY	
ADDRESS	
PHONE	

I have read this form and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this document upon my request.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Highview
A Muller Company
1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Highview
A Muller Company

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Employee Name: _____ **Date of Injury:** _____
Employer Name: _____ **Date of Birth:** _____

I hereby authorize Highview National Insurance Company their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

1. Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Highview National Insurance Company representatives to contact the attending physicians involved in the treatment of all related conditions.

2. All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

The released information is required for the following reasons:

1. To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in this work-related injury or injuries.

2. To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

3. To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

4. To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

5. To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

A copy or fax is as valid as the original.

_____

_____

_____

(Names, addresses, and phone numbers of providers)

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

Signed: _____ Date: _____

Highview
A Muller Company
1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Highview™
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PENNSYLVANIA

ADDITIONAL REFERENCES

FOR MORE INFORMATION, VISIT: WWW.PA.GOV/AGENCIES/DLI/PROGRAMS-SERVICES/WORKERS-COMPENSATION.HTML

PENNSYLVANIA