CM REGENT
INSURANCE COMPANY

CM Regent Insurance Company

New Claim Checklist

Your Injury – Our Concern

What to do if You Are Injured at Work?

As soon as practicable, report the incident to your Supervisor, Human Resources, or your employer's Worker's Compensation Coordinator so they can report it to our office, even if you don't think you need medical treatment.

- Make sure your employer has your most up-to-date contact information, including phone numbers, home address, and personal email.

Your employer will file your claim electronically with CM Regent Insurance Company, who will assign an Injury Manager to work with you going forward.

- If you require medical treatment, your employer will give you a copy of your Injury Report that will include your confirmation/claim number. To avoid delays, take the Injury Report with you to your initial doctor's appointment.
- When seeking medical attention on for a work-related injury occurring after hours, tell the medical provider that yours is a Workers' Compensation injury. Remember to report the incident to your employer the next business day.

Your employer should give you a copy of your Provider Panel.

- A Provider Panel is a list of medical providers you must with the first 90 days following a work-related injury. You must sign a form acknowledging your receipt of the Provider Panel information.

****PLEASE NOTE****

If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

- Communicate any concerns about your treatment to your medical provider and to your CM Regent Ins. Co. Injury Manager.

Continued...

The following services should be scheduled through the providers listed below during the first 90 days of a claim.

- MRI, CT, EMG – One Call Medical (800-453-0574)
- Physical Therapy – Alignetwork (866-389-0211)
- Prescriptions – Corvel (800-563-8438)

A Model of Care and Concern — How We Can All Work Together

- You can expect contact from your Injury Manager between 8 a.m. and 5 p.m. to discuss your injury and if applicable, a treatment strategy.
- Watch your mail for paperwork that will need to be filled out immediately and returned to our office or given to your medical provider. A self-addressed stamped envelope will be included for your use for the materials that are to be sent back to CM Regent Insurance Company.
- A pharmacy card will be issued to you once your claim has been accepted and Workers' Compensation benefits are approved. This card is to be used for all prescription purchases as prescribed by your medical provider.
- Call your Injury Manager after every doctor appointment to relay the most current medical and return- to- work information.

CM Regent Insurance Company wants to help get you back to your pre-accident condition as quickly as possible.

If you have any questions or concerns, please do not hesitate to call our office: 866-402-6600

CM REGENT INSURANCE COMPANY

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:		Employer Address:			County:
Employee Name (last, first, initial):		Home Phone #:	Gender: M ☐ F ☐	Marital Status: M ☐ S ☐ Dep.:	
Home Address (street, city, state, zip code):					County:
Social Security #:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:
Location of Incident (building, room, etc.):			Type of Injury (cut, sprain, etc.):		
Injured Body Part:			Cause of Injury (machine, tool, equipment, liquid, etc.):		
Employee's Job Title:	Hours Worked Per Week:		Name of Witness(es):		
Description of Incident (please describe in detail what happened):					
Employee Name:		Employee Signature:			Date:
Employee's Supervisor Name:		Employee's Supervisor's Signature:			Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: ☐ New ☐ Other (describe):

Treatment/First Aid:

Diagnosis:

Disposition:

☐ Return to work without limitations
☐ Return to work with limitations (describe):
☐ May return to work on:
☐ Follow-up appointment with: on

Signature of medical/first aid provider **Date:**

Medical Facility Address:

Medical Authorization Form

Injured Worker: _____

Claim Number: _____

Date of Injury: _____

School District: _____

Your Workers' Compensation claim is in the process of being submitted to CM Regent Insurance Company. An Injury Manager will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Insurance Company at (866) 402-6600.

If you require the following services, please contact the designated providers:

- MRI, CT, EMG – contact One Call Medical @ 800-453-0574
- Physical Therapy – contact Alignetwork @ 866-389-0211
- Prescriptions – contact Corvel @ 800-563-8438

Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.

Thank you for your cooperation.

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize CM Regent Insurance Company and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.

This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Sign: _____ Date: _____

Date of Birth: _____

Claim Number: _____

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.

RIGHTS AND DUTIES FORM - SIDE 1

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.

NOTICE TO EMPLOYEES
TUNKHANNOCK AREA SCHOOL DISTRICT

CM Regent Insurance Company, Workers' Compensation Division, the claims administrator for the school district's workers' compensation carrier, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act.

IN CASE OF A WORK-RELATED INJURY

1. 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 licensed physicians or practitioners of the healing arts listed.
2. You must continue to visit one of the listed providers for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.

DESIGNATED PHYSICIANS

See Reverse Side

You recognize and agree that your employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). You also acknowledge that you have been presented with this written notice setting forth your rights and duties under Section 306(f.1)(1)(I) of the Pennsylvania Workers' Compensation Act. Your rights and duties include the following:

1. I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for **ninety (90)** days from the date of first visit to a designated provider.
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
4. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.
5. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period.
6. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.
7. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.
8. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and
9. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the treatment shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion).

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and understand my rights and duties.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

_____ EMPLOYEE'S NAME (PLEASE PRINT)

_____ DATE

_____ WITNESS

Jan-22

TUNKHANNOCK AREA SCHOOL DISTRICT
DESIGNATED PHYSICIANS

MEDICAL PROVIDER	ADDRESS	PHONE	SPECIALTY
Concentra Medical Center	268 Highland Park Blvd. Wilkes-Barre, PA 18072	570-822-8831	Occupational Medicine/Urgent Care
Advanced Urgent Care	305 Mulberry Street Scranton, PA 18503	570-909-9972	Occupational Medicine/Urgent Care
Guthrie Clinic – Tunkhannock	512 Towne Plaza, Ste. 124 Tunkhannock, PA 18657	570-836-4294	Urgent Care
Geisinger - Tunkhannock	110 Trieble Road Tunkhannock, PA	570-996-2700	Family Practice
Patrick Murray, MD	1240 SR 307 Lake Winola, PA 18625	570-378-3047	Family Practice
Orthopedic Consultants	909 US State Route Six West Tunkhannock, PA 18657 390 Pierce Street Kingston, PA 18704	570-836-7600 570-288-3535	Orthopedics
Delta Medix Surgery	743 Jefferson Ave, Suite 103 Scranton, PA 18510 225 Penn Ave. Scranton, PA 18503	570-344-1231 570-342-7864	General Surgery
Vithalbhai Dhaduk, MD	235 Main Street Dixon City, PA 18519	570-963-8803	Neurology
Neuroscience Institute Dr. P Shripathi Holla	1800 Mulberry Street Scranton, PA 18510	570-969-8888	Neurosurgery
Northeastern Eye Institute	304 W. Tioga Street Tunkhannock, PA 18657	570-836-2224	Ophthalmology
Tunkhannock Chiropractic	608 Hunter Hwy Suite 112 Tunkhannock, PA 18657	570-836-0558	Chiropractor
Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp Solutions	Call Toll Free for Closest Location	1-888-594-4001	Diagnostic Testing
S1 Medical	Call toll free for location nearest you	888-945-5055	Physical Therapy, Diagnostic Studies, DME, Home Health
Corvel	For prescriptions, please call	800-563-8438	Pharmacy

UPDATED: 01-22

CM REGENT™
INSURANCE COMPANY

Patient Name: _____
Date of Birth: _____
Claim#: _____

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk:
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
   ☐ No restrictions
2. In an 8-hour workday, patient can sit:
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
   ☐ No restrictions
3. In an 8-hour workday, patient can drive car/truck:
   (Minutes at one time) ☐ 10-30 ☐ 30-60
   (Hours at one time) ☐ 1-3
   ☐ No restrictions
4. Patient can lift/carry:

Maximum lbs.:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

   ☐ No restrictions or above
5. Patient can use hands for repetitive:
   A. Simple Grasping ☐ Yes ☐ No
   B. Pushing & Pulling ☐ Yes ☐ No
   C. Fine manipulation ☐ Yes ☐ No
   ☐ No restrictions
6. Patient can use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No
   ☐ No restrictions
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No restriction
   ☐ Yes – Please explain _____
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No restriction
   ☐ Yes – Please explain _____
10. When will patient be released to return to work:
    Light duty _____ Full duty _____
11. Will patient be required to use any assistive devices or braces?
    ☐ No restrictions
    ☐ Yes – Please explain _____
12. Additional comments: _____

_____ Physician's Signature _____ Date

Thank you for your assistance,

PLEASE FAX TO: **CM REGENT INS. CO. WORKERS' COMPENSATION DIVISION @ 866-402-6601 AND PROVIDE A COPY TO THE PATIENT**

CM REGENT™
INSURANCE COMPANY

TRANSITIONAL DUTY RTW FORM

School District Name: _____

School District Address: _____

School District Contact: _____

School District Phone Number: _____ Fax Number: _____

Employer: Provide this form to the attending Physician

*****REMINDER TO MEDICAL PROVIDER*****

EMPLOYEES ARE OUR MOST VALUABLE ASSET!

WE OFFER MODIFIED DUTY!

It is the policy of _____ to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding our modified duty program, please contact us.

Thank you!

(To be completed by the Physician)

_____ Yes, employee may return to work on regular duty (no restrictions).

_____ Yes, employee may return to work on modified duty (see restrictions).

_____ No, employee may NOT return to work (see restrictions).

Physician's Signature: _____

Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:

P.O. Box 813, New Cumberland, PA 17070-0813
866-402-6600 Fax: 866-402-6601 www.cmregent.com