ACCIDENT / INJURY QUESTIONNAIRE

IMPORTANT: In order to process your Accident/Injury Claim promptly, please complete and submit these forms within 5 business days. Asterisk indicates required field.

* NAME:____
(First) (Middle Initial) (Last)

* SOCIAL SECURITY #:__________________________* DATE OF BIRTH:__________________________

* ADDRESS:____________________________CITY:____________STATE:______ZIP CODE:___________

* PHONE # _____________________ * MARITAL STATUS:________

* # OF DEPENDENTS UNDER 18 YEARS OF AGE:____

* NATURE OF YOUR WORK (Job Title/duties): ____

* SUPERVISOR NAME:____

* Did the accident occur on the work site? (Yes/ No) ___________________

* Provide work site company name and specific location where incident occurred: _______________________

* Date of Injury: ______________________________ * Time of Injury:______________________________

* Work Shift Start Time: _________ AM ___/PM ___ * Work Shift End Time: _________AM ___/PM ___

* Did you lose paid work time as a result of the injury? (Yes/No)_________*(If no, skip next two lines)*

# of missed work days:______________________Date of first day off work: _____________

Expected return to work date?___________Date Returned: _____________

* Please list any work restrictions as a result of the accident/injury: ___________________________________

* Nature of injury: ____

* Body part(s) injured: ____

If applicable: Right ____ Left ____ Both _____

* Cause of accident/injury: ____

* Provide a detailed description of accident/injury: ____

____

* Were safeguards or safety equipment provided? (Yes/No) __________

* What could have been done differently to avoid the accident/injury? ________________________________

____

Witness name:____

Witness name:____

________________________   ________________________

*** SIGNATURE**   *** DATE**

IMPORTANT: ALSO SIGN THE ATTACHED AUTHORIZATION & (2) ACKNOWLEDGEMENT FORMS

NOTICE:
Any person who knowingly and with intent to defraud any insurance company or other person files anapplication for insurance or statement of claim containing any materially false information or conceals for the purposes 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.

AUTHORIZATION FOR DISCLOSURE
OF PROTECED HEALTH INFORMATION FOR WORKERS'
COMPENSATION PURPOSES (HIPAA COMPLIANT)

I hereby authorize all healthcare providers to use and disclosure my Protected Health Information (PHI) as described in this authorization. A photocopy of this Authorization is as valid as the original.

PATIENT IDENTIFICATION INFORMATION

Patient's Full name: ____

Last First Middle

Address: ____

Social Security No.: XXX-XX-_ _ _ _ Date of Birth: (Month /Day)

Name and address of recipient: Eastern Alliance Insurance Group
P.O. Box 83777
Lancaster, PA 17608-3777

RELEASE

The purpose of use or disclosure of patient information is for my workers' compensation claim.

I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: hospital and emergency operational logs, outpatient records; medical reports; clinical notes; nurses' notes; physical therapy records; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; bills for services; payments received; and any other relevant and material information in the health care provider's possession. This Authorization also includes, if applicable, drugs/alcohol, psychiatric/psychological services and social work disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or ARC reports. This authorization includes the release of documents in the possession of the healthcare provider whether or not created in your office or by another healthcare provider.

I also agree that any and all of my health care providers may discuss the details of my medical information with the representatives of the above-named recipient. However, the health care provider will not condition treatment on the completion of the authorization.

CONDITIONS

I understand that information released in response to this authorization may be used or disclosed to administer, determine and/or litigate my claim. Patient information may be redisclosed to Eastern Alliance, their agents and representatives; authorized information is subject to disclosure to other parties, and any other person, firm or entity that releases materials pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that this authorization is valid until my case has been closed and for up to one year from the date of closure. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Eastern. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I have read this Authorization and understand that I can retain a copy.

______________________________ ______________________________

Patient, or the patient's personal representative **Date**

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Medical Treatment for Work Injury or Occupational Illness Procedures.

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

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

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

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

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

Employee Signature___________________________________ **Date** _________________________

WORKERS' COMPENSATION INFORMATION

To all employees:

The workers' compensation law in Pennsylvania 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 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, PA 17104-2501
Telephone number within Pennsylvania: 800-482-2383
Telephone number outside of this Commonwealth: 717-772-4417
TTY- 800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA Keyword: workers comp.

Employee Acknowledgement and Signature

I,________________________, (*employee of JFC*), certify that I received, read, and understand the above information.

Employee Signature ____________________ **Date** ____________________