The enclosed packet of forms must be completed for each work related injury. It is very important that all the forms are complete, signed and immediately returned. Please provide as much detail as possible in your description.

Please fax or email these forms to:

724-704-7061 Attn: Claims Department

claimssupport@synergyinsurance.com

INCIDENT REPORTING COVER SHEET

Please be sure to attach this cover letter to all Incidents that you are sending over to Synergy's Claims Department.

Do you have any concern regarding this incident? **Yes** ☐ **No** ☐

If yes, the space below has been provided for you to list any concerns or information that you want the Claim Manager to be aware of when beginning the investigation.

Does Employee have any pre-existing conditions or prior injuries? **Yes** ☐ **No** ☐

RED FLAGS/CONCERNS:

☐ Please indicate by checking this box if the employee who was involved in this incident speaks a language, other than English, as the primary language.

What language does the employee speak in his/her daily communication: ____________________

☐ Please check if medical treatment was sought by the injured employee, other than first aid

Please fax or email all forms: Attn: Claims Department

Fax #: (724) 704-7061

Email: claimssupport@synergyinsurance.com

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Supervisor Work Comp Checklist

The enclosed packet of forms must be completed for each work related injury. It is very important that all the forms are complete, signed and immediately returned. Please provide as much detail as possible in your description.

EMPLOYEE COMPLETES THE FOLLOWING:

- ☐ **Employee Incident Report**: must be signed by the injured employee for each work related injury. This provides a written signed statement from the employee.
- ☐ **Medical and Workers' Compensation Claim Authorization**: is a form that should be signed by employees for each work related injury. It prevents medical providers from delaying the release of medical records and documentation.
- ☐ **Panel of Physician Acknowledgment Form**: Employees are required to sign this form as soon as possible following each work related injury. If the employee refuses to sign, it is to be so noted and witnessed by the supervisor on the form.
- ☐ **Fraud Notice**: This form documents that the employee has been advised of what constitutes fraud under the Workers' Compensation Act and what the penalties are.

The employee must take the following forms to the panel physician or pharmacy:

- ☐ **Pharmacy Letter**: notifies the panel pharmacy that the employee has reported a Workers' Compensation claim.
- ☐ **Billing Information**: notifies the provider with our billing information so the injured employee does not receive any bills.

SUPERVISOR COMPLETES THE FOLLOWING:

- ☐ **Supervisor Accident Investigation**: must be completed by the supervisor as soon as possible after the injury. It is critical that any fact discrepancies from the employee report be noted and documented.
- ☐ **Acknowledgement & Confirmation of Accident Repeater Policy**: must be completed by the supervisor and employee documenting employee's knowledge of the policy and addressing the appropriate corrective action.
- ☐ **Witness Statement**: must be completed by all witnesses (if any) as soon as possible after the injury.

Please fax or email these forms to:

(724) 704-7061 Attn: Claims Department
claimssupport@synergyinsurance.com

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OSHA Log # ________
Department # ________
Date of Hire ________

Employee Incident/Accident Report

Employee Name: ____
Last First Middle Initial

Address: ____
Street City County State Zip Code

Phone Number: ______________________ Cell Number: ______________________

Email Address: ____

Date of Birth: __________ Age: _____ Sex: _____ Marital Status: _____ SS # ______________

Number of Dependents: ______ Date of Hire: ______ Job Title: ______________ Full or Part Time: ______

Personal Physician: ______________________ Phone Number: ______________________

Date Employer Notified of Incident: ______________ Location: ______________________

Date of Incident: __________ Time of Incident: ________ AM / PM Time You Began Work: __________

Do you have other employment?: Yes ______ No ______ If yes: Full-time ______ Part-Time______

If yes, name and address of employer: ____

____

How Did Injury Occur?: ____

____

Describe any pain or injury that you are presently experiencing: ______________________

____

Have you ever had previous pain or injury to the body parts described above? Yes ______ No ______

If yes, please give details: ____

____

Were you seen by Physician? Yes ______ No ______ If Yes, Who? __________
When? __________ Where? __________

Was First Aid Administered? Yes ______ No ______ By Whom? __________
When? __________ Where? __________

Name of Anyone Who Witnessed Incident: ______________________________

______________________________ ______________________________
Signature of Injured Employee Date Witness Signature Date

Synergy Claims Management Company
30 East State Street
Sharon, PA 16146
Phone: (724) 704-7060
Fax: (724) 704-7061

MEDICAL AND WORKERS' COMPENSATION CLAIM AUTHORIZATION

Insured:

Injured Worker: ____

Date of Injury: ________________________

Date of Birth: ________________________

Social Security Number:___________________

For purposes of and in conjunction with my worker's compensation, I hereby authorize and direct you to permit the bearer hereof, an authorized representative of Synergy Claims to inspect, examine, make, or be furnished with copies of **ALL** documents in connection with my illness, health, condition, injury, treatment, consultation, medical history, testing, surgery, emergency room and/or outpatient treatment, and confinement, including x-rays, and scanning studies and interpretive reports **regardless of the dates of service or purpose for treatment.**

I may later revoke this authorization by notifying an authorized representative of Synergy Claims in writing of my desire to revoke it. However, I understand that any action already taken in reliance upon this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that the information supplied may be subject to re-disclosure by the person or class of persons or facility receiving it, within the context of my worker's compensation, and would then no longer be protected by federal privacy regulations. Re-disclosure may include to a physician appointed by Synergy Claims or its authorized representative, to examine any x-rays or other films taken of me, or records regarding my physical condition and treatment.

____ ____________________

Signature of Injured Worker or Authorized Representative *Date*

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work related injuries and illnesses during the first 90 days of treatment. This list is also posted at ____ for you to review.

If you are injured at work or suffer an occupational illness, you have certain RIGHTS and DUTIES under Section 306(f.1) (1) (i) and Section 121.3b of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The 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 No. within Pennsylvania: 800-482-2383   Telephone No. 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

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

****

Your signature on this form indicates that you have been informed of and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before signing this form.**

I CERTIFY THAT I HAVE BEEN PROVIDED WITH, READ AND UNDERSTOOD THE INFORMATION SET FORTH ABOVE, AND ON THE PANEL, CONSISTENT WITH THE REQUIREMENTS OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT. I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

□ TIME OF HIRE   □ WHEN I WAS INJURED   □ OTHER

INJURED EMPLOYEE: ____ DATE: ______________________

EMPLOYER REPRESENTATIVE: ________________________________ DATE: ______________________

Synergy Claims
Reducing Costs, Managing Claim Outcomes

CPS
Corporate Pharmacy Services

PriorityRx Prescription Payment Authorization Form

Please keep this Authorization Form on file with script for auditing purposes

Employee:

Please note: If your injury is determined to be work related, you may receive a permanent prescription card in the mail. Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form. Please submit the prescription using the processing information listed below. Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

Temporary Work Comp Prescription Card
PLAN limit: Max Day Supply is 5, Max $$ Amount is $250

Name: ______________________________

Date of Birth: ______________________________

ID/SSN: ______________________________

Prior Authorization #: ______________________________

PA# = Date of Injury in YYMMDD format (ex. July 20, 2014 would be 140720)

Processing Information:

Processor: EHO (Employer Health Options)
BIN#: NDC 004527
Envoy/WebMD 003241
CVS Condor Code 15721
Eckerd's/Rite Aid Condor Code 2185
Version: D.O
Group#: 70831

Questions? Call (866) 429-1116

By signing below, I acknowledge that I have been provided the temporary prescription card should a physician prescribe any medications

______________________________ ______________________________ ______________

Print Name of Injured Employee **Signature of Injured Employee** **Date**

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Synergy Claims Management Company
30 East State Street
Sharon, PA 16146
Phone: (724) 704-7060
Fax: (724) 704-7061

Normal Office Hours 8:30 a.m. to 5:00 p.m.

NOTICE TO PENNSYLVANIA EMPLOYERS AND EMPLOYEES

In accordance with the Anti-Fraud Legislation passed by the Commonwealth of Pennsylvania, insurance carriers are required to advise all policyholders and claimants of the following:

> **Any person who knowingly and with the 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, in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties.**
>
> **"Statement" is defined as any oral or written presentation or other evidence of loss, injury, or expense. This includes, but is not limited to, any notice, statement, proof of loss, diagnosis, prescription, hospital or doctor records.**
>
> **Workers' Compensation fraud is a felony, punishable by payment of fines of up to fifty thousand dollars ($50,000) or double the value of the fraud or to undergo imprisonment for a period of not more than seven (7) years, or both.**

By preventing fraud, the best interests of all parties are protected. Resources can then be properly devoted to legitimate claims, helping to ensure the speedy resolution of an injured employee's claim.

A message from the
Management Team of Synergy Claims Management Company

Signature of Employee: ___________________________________ **Date:** __________________________

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Synergy Claims

Reducing Costs, Managing Claim Outcomes

WITNESS STATEMENT

Please answer each questions thoroughly and sign where indicated.

Name:____

Address:____

City State Zip Code

Phone: ____________________(cell) ____________________(home)____________________

Employer: ____

Position: ____

Injured Worker: ______________________________________

Incident date: ____________ Time: _____________ Location:______________________

Did you see the incident occur? Yes ☐ No ☐ Do you wear glasses or contacts? Yes ☐ No ☐

In your own words, please describe the events prior to, during, and immediately after the incident. If you need more space please use the back of this page.

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Please sign and date your statement of facts as you witnessed.

____

Signature **Date**

Synergy Claims
Reducing Costs, Managing Claim Outcomes

SUPERVISOR INCIDENT INVESTIGATION FORM

Incident Date: ____________________ Incident Time ______________

INJURED EMPLOYEE INFORMATION:

Name / Job Title ____

Type of Injury ____

DETAILS OF INCIDENT:

DEPARTMENT: ______________________________ **LOCATION:** ______________________________

Description of the Incident: **Recreate incident with Injured Employee**

____

____

____

____

Other persons who rendered assistance or witnessed the incident: **Complete Witness Statement**

____

Supervisor's Investigation of Cause of the Incident: **Complete Root Cause Analysis Form**

____

____

____

Corrective Action Recommended to Prevent Reoccurrence: Review with Injured Employee

1. ______________________________ Person Responsible / Date ______________________

2. ______________________________ Person Responsible / Date ______________________

3. ______________________________ Person Responsible / Date ______________________

Employee Comments:

____

____

____

Injured Employee Signature: ______________________________ Date: ______________________

Department Supervisor's Signature: ______________________________ Date: ____________

Manager's Signature: ______________________________ Date: ____________

BILLING INFORMATION SHEET

For:

____

Workers' Compensation Claims

ALL MEDICAL BILLS MUST BE ON A UB92 OR HCFA 1500 FORM ACCOMPANIED WITH MEDICAL REPORTS AND SUBMITTED TO:

SYNERGY CLAIMS MANAGEMENT COMPANY
PO BOX 1285
Canonsburg, PA 15317

Please CALL or FAX
Synergy Claims Management Company
With any questions at:

Phone: (724) 704-7060
Fax: (724) 704-7061

Effective: __________________