

# WORKERS' COMPENSATION PROCEDURE MANUAL



School District of Philadelphia

# New Procedure for Filing a Workers' Compensation Claim

1. **Immediately notify your Climate and Safety officer on any claim that appears to need emergent care.** (e.g., problems breathing, chest pains, severe headaches, disoriented affect, severe bleeding, poisoning, sexual assault).
2. **Call the School District Serious Incident Desk at 215-400-6100.** They will give you an incident report number.
3. **The Injured employee MUST Sign the Workers' Compensation Employee Notification.** (Employee Notification form, also called the Rights and Obligations form) and give a copy of the form to the injured employee.
  - a. Unless it is a true emergency where the injured employee is unable to sign, the injured employee must sign the form before the leave the building.
    - i. If they are **unable to sign** the Employee Notification, send them the notice by certified mail / Return Receipt Requested.
    - ii. If they **refuse to sign** the Employee Notification, call in a secretary or other administrator to witness the refusal to sign. Give the injured employee another chance to sign. If he/she refuses, write, "Mr. /Ms. \_\_\_\_ refused to sign this notice." You sign and date the notation and have the witness sign the notation. If either witness's signature is illegible, print the name as well.
    - iii. You keep the original in the employee's file and fax the side with the signature to the Office of Risk Management at **215-400-4591**.
4. **File the claim with PMA** by going online to [www.pmacompanies.com](http://www.pmacompanies.com).  
User name: 7650013 and Password: newclaim  
If you can not get access to the PMA claim site call PMA at **1-888-476-2669**.  
**You will get a claim number on the spot. You will put this onto the pharmacy card (step6).**
5. **Give the injured employee the Medical Provider List** and explain that they must obtain their treatment through one of these doctors or the District will not be responsible for the bills.
6. **Give the injured employee the pharmacy card (the "Express Scripts" card)** and explain to the injured employee that they should give this to the pharmacist, that it will act like a prescription card so that they do not need to pay anything out of pocket should the claim be accepted as compensable. Fill in the injured employees name for him/her and put the claim number in the section asking for the Social Security Number.

If you have any questions or problems, please contact  
**CarolAnn Kenney, Workers' Compensation at 215-400-5592**

# Filing Claims on the Internet

## LOGON INSTRUCTIONS

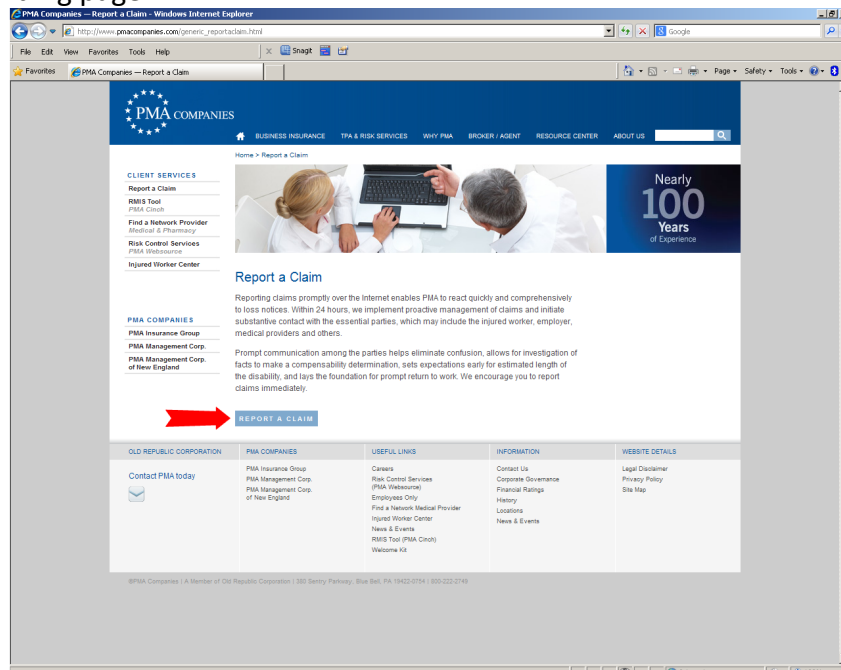
User Name: 7650013

Password: newclaim

Open an Internet browser session. On the URL address line, type **www.pmacompanies.com** and you will see PMA's Home Page.

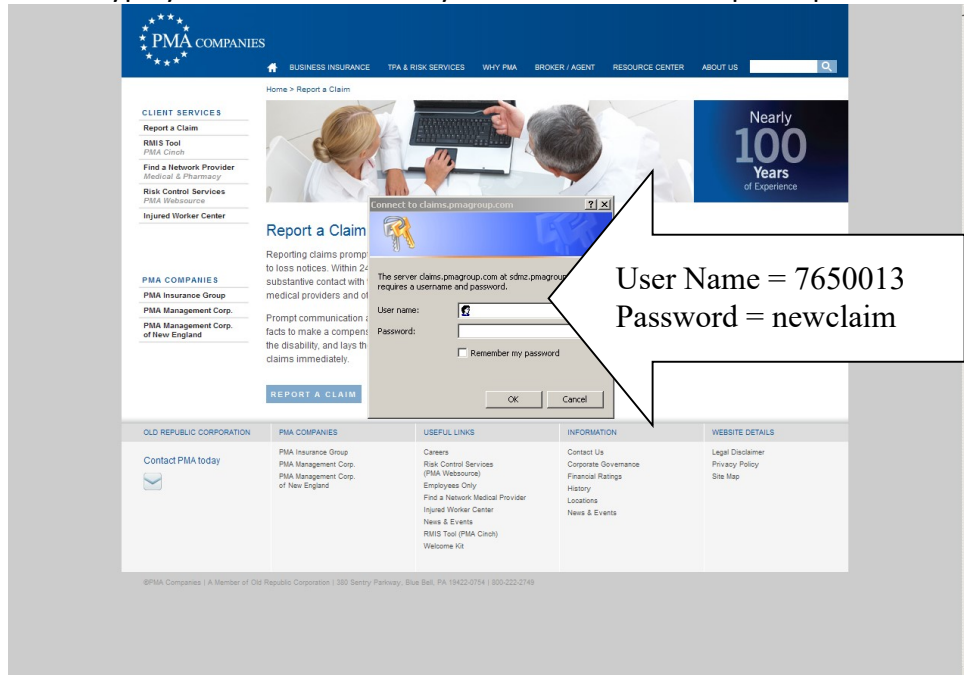


Click "Report a Claim."  
See the Report A Claim landing page.



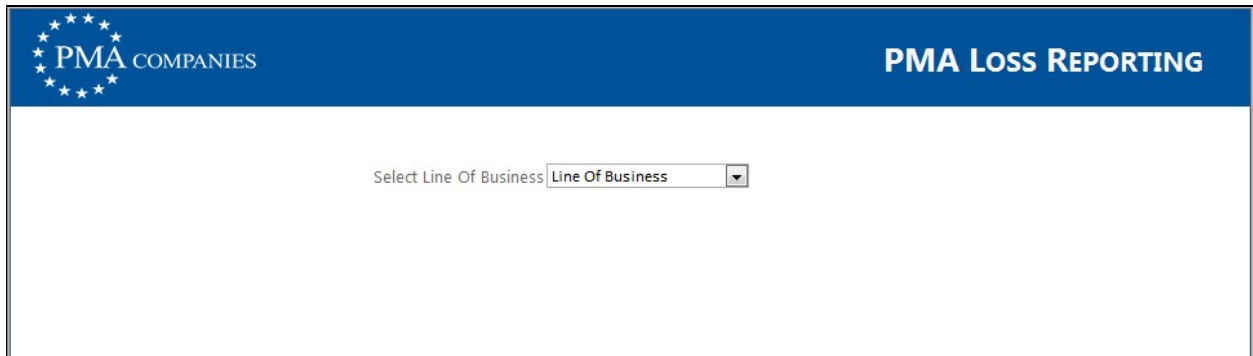
Click REPORT A CLAIM.

You will see a login screen. Type your User Name and your Password in the spaces provided. Click OK.

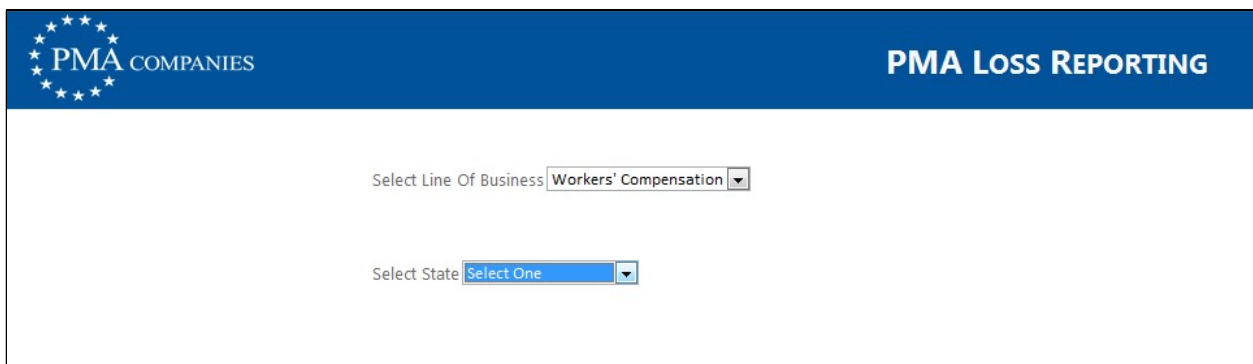


After a few seconds, you will see the New Claim Entry main screen.

From the drop-down, choose the type of claim you want to report (Workers' Compensation, Automobile, Liability, Property). If you only have one type with PMA, you will not see this screen.



For Worker's Compensation only, choose your accident state and click **Go**.



Complete each of the screens. Click the blue headings to move between the various screens. Note required fields are blue. For all dates, use the format mm/dd/yyyy, like 06/20/2013 for June 20, 2013. For telephone numbers and social security number, do not type the dashes.

## WORKERS' COMPENSATION

### Employee Information

\* Fields in Blue are required

Location  Location of Loss is required

Employee First Name  Employee First Name is required Employee Last Name  Employee Last Name is required

Address  Employee Address is required

City  Employee City is required

State  Employee State is required Zip  Employee Zip is required

Telephone  SSN  SSN is required

Sex

Dates must be in mm/dd/yyyy format

Birth Date  Birth Date in (mm/dd/yyyy) is required Hire Date

Marital Status  Number of Dependents

Employment Status

Occupation/Job Title  Employee Occupation is required

### Occurrence Information

### Contact Information

### Customer Special Coding

### Claim Submission

If you missed entering any required fields, you will see a screen reminding you (in red) about missing information. Open each red section, complete the missing information, and return to the Claim Submission section.

## WORKERS' COMPENSATION

### Employee Information

\* Fields in Blue are required

Location  Location of Loss is required

Employee First Name  Employee First Name is required Employee Last Name  Employee Last Name is required

Address  Employee Address is required

City  Employee City is required

State  Employee State is required Zip  Employee Zip is required

Telephone  SSN  SSN is required

Sex

Dates must be in mm/dd/yyyy format

Birth Date  Birth Date in (mm/dd/yyyy) is required Hire Date

Marital Status  Number of Dependents

Employment Status

Occupation/Job Title  Employee Occupation is required

### Occurrence Information

### Contact Information

### Customer Special Coding

### Claim Submission

Sample Workers' Compensation screens continue below.

**Occurrence Information**

\* Fields in Blue are required

Date of Injury/Illness  Accident State

Accident Cause

Injury Nature

Body Part

Side of Body

Accident Description

Maximum 500 Characters.

Time Employee Began Work Hour  Minute   AM  PM

Time of Occurrence Hour  Minute   AM  PM

Date Employer Notified  Last Date Worked

Date Expected to Return to Work:  Date Returned to Work:

Full Pay For Date of Injury?

Hours Worked Per Day  Days Worked Per Week

Payment Frequency

If Fatal, Date of Death:

Is the Injured Worker Losing Time?  Date Disability Began:

Is the Injured Worker On Modified Duty?  Date Modified Duty Began:

Where did Injury/Illness occur?  
Injury/Illness Occurrence Address   
City  State

Zip

Did Injury or Illness occur on Employer's Premises?  Yes  No

Were Safeguards or Safety Equipment Provided?  Yes  No Were They Used?  Yes  No

Does Employer Question the Claim?

Was Employee Injured During Employment?

Were Drugs or Alcohol Involved?  Is Employee Represented By Attorney?

**Contact Information**

\* Fields in Blue are required

**Physician/Health Care Provider Name and Address:**

Name  Telephone

Address

City  State  Zip

**Hospital/Provider Information**

Name  Telephone

Address

City  State  Zip

**Other Information**

Date Prepared:

Preparer's First Name  Last Name

Telephone

Employer Contact First Name  Last Name

Telephone

Witness First Name  Last Name

Telephone

**Claim Submission**

\* Fields in Blue are required

The Claim Entry Wizard has been completed. You may add additional comments below and click the Submit button to send the data to PMA.

**Comments**  
Enter miscellaneous claim details in the comments box below.

Comments:

Maximum 900 Characters.

Record Only

**Claim Information Email**

Click on the checkbox below to receive an email copy of the claim information just entered.

Send Email Copy

Email Address(es) - Multiple addresses can be entered separated by a comma.

Check the **Record Only** box when the claim is for informational purposes only. For Workers' Compensation, this means an injured worker who will **not** be seeking medical treatment.

Type any additional information about the claim into the Comments box.

Click the **Send Email Copy** and **type** your email address in order to receive a copy of these screens after you submit the claim. Add additional recipients to the list by typing a comma and then adding the next address.

Click **Submit Claim** when you are finished. You will receive a claim number immediately. Record this claim number for your records.

**Claim Number**

Claim Number : **W001171292**

To submit additional documentation, such as internal investigation reports, surveillance footage, medical reports, or photographs, click the Attached File(s) button. You will see the folders on your computer. Select the folders you would like to include with the claim and then click Upload File(s). When the upload is complete, you can attach more files, exit or start entering a new claim.



Claim Number

Claim Number : **W001171292**

**Attach File(s)**

- IMAG0104.jpg ❌
- IMAG0107.jpg ❌
- common abbreviations.doc ❌
- Cell Phone List.xls ❌

**Cancel all Uploads**

Attachments will not be uploaded unless Upload File(s) button is clicked.

**Upload File(s)**

**New Claim**

Claim Number

Claim Number : **W001171292**

**Attach File(s)**

Files

- IMAG0104.jpg (1.0MB)
- IMAG0107.jpg (2.0MB)

Total attachments submitted for this claim : 2

**New Claim**

To enter another claim, choose New Claim from bottom of the screen. When you are finished entering claims, choose Exit from the menu. Click **Yes** to close PMA New Claim Entry.

**Supported Types of Attachments, in file sizes up to 50 megabytes each:**

Document Type	Extension	File Type	Document Type	Extension	File Type
BITMAP	.bmp	Image	RTF	.rtf	Text
GIF	.gif	Image	MSEXCEL	.xls	Excel Document
JPEG	.jpg	Image	MSEXCEL	.xlsx	Excel Document
TIF	.tif	Image	POWERPOINT	.ppt	Powerpoint Document
TIFF	.tiff	Image	MPEGAUDIO	.mpg	Audio File
HTML	.html	Browser File	AIFFAUDIO	.aiff	Audio File
TEXT	.txt	Text	WAVAUDIO	.wav	Audio File
XML	.xml	Browser File	MPEGVIDEO	.mpg	Video File
DCARFT	.rtf	Text	QUICKTIME	.mov	Video File
MSWORD	.doc	Word Document	VIDEOCHARGER	.mpg	Video File
MSWORD	.docx	Word Document	ASFVIDEO	.asf	Video File
PDF	.pdf	PDF	AVIVIDEO	.avi	Video File



# **WORKERS' COMPENSATION**

## **EMPLOYEE NOTIFICATION**

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physician or other health care providers, medicines and supplies, as and when needed.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from 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 do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide for by same for the 90 days.

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 the services rendered if such services are determined to have been unreasonable or unnecessary.

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.

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

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **WORKERS' COMPENSATION**

## **EMPLOYEE NOTIFICATION**

### **Workers' Compensation Information**

1. 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.
2. 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.
3. You should report immediately any injury or work-related illness to your employer.
4. Your benefits could be delayed or denied if you do not notify your employer immediately.
5. If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.
6. 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 S. Cameron Street, Room 103, Harrisburg, PA 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); [www.state.pa.us](http://www.state.pa.us); PA Keyword: workers comp.



## NOTICE TO EMPLOYEES



### Your employer has provided for the payment of benefits under the Workers' Compensation Act of this State **IN CASE OF WORK-RELATED INJURY**

- If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prostheses, including training in their use.
- In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must immediately advise your supervisor of your injury, and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

#### **DESIGNATED PHYSICIANS**

**(including address, telephone number, and area of medical specialty)**

#### **CLINICS**

**Temple Health – Episcopal Campus**  
Occupational Medicine Clinic  
100 E. Lehigh Avenue  
M.A.B. Bldg. – Suite 205  
Philadelphia, PA 19125  
  
215-707-0485

**Mercy WorkCare – Philadelphia Hospital**  
Occupational Medicine Clinic  
(park and enter through ER)  
  
501 S. 54th Street  
Philadelphia, PA 19143  
215-748-9327

**WORKNET Occupational Medicine**  
  
Occupational Medicine Clinic  
1017 4th Avenue, Suite 200, Bay 1  
Essington, PA 19029  
610-521-6880

**WORKNET Occupational Medicine**  
(at the Navy Yard)  
Occupational Medicine Clinic  
4050 S 26th Street  
Philadelphia, PA 19112 215-467-5800

**WORKNET Occupational Medicine**  
(at former Hahnemann Hospital)  
Occupational Medicine Clinic  
Broad And Vine St, Room 131  
Philadelphia, PA 19102  
215-762-8525

**WORKNET Occupational Medicine**  
(at Roxborough Hospital)  
Occupational Medicine Clinic  
5800 Ridge Avenue, Suite 234  
Philadelphia, PA 19128  
215-487-4540

**Concentra Medical Center**  
Occupational Medicine Clinic  
2804 Southampton Road  
Philadelphia, PA 19154  
215-677-0930

**Concentra Medical Center**  
Occupational Medicine Clinic  
2010 Levick Street  
Philadelphia, PA 19149  
215-537-4755

#### **PHYSICIANS/SPECIALISTS**

**One Call Imaging Network MRI**  
221 N Broad Street, Ste 101  
Philadelphia, PA 19107  
For this or other locations call  
  
800-453-0574

**Align Networks (Including NovaCare facilities)**  
*Chiropractor / Physical Therapy*  
521 N 22<sup>nd</sup> Street  
Philadelphia, PA 19130  
For this or other locations call  
866-389-0211

**MEDRISK (Including NovaCare facilities)**  
*Physical Therapy*  
511 N Broad Street  
Philadelphia, PA 19123  
For this or other locations call  
800-225-9675

Barnaby, Arthur J., MD Surgery: General  
NPS Surgery Internal Medicine  
2701 Holme Avenue, Suite 104  
Philadelphia, PA 19152  
  
215-331-8897

**Rothman Institute**  
*Orthopedics*  
925 Chestnut Street  
5<sup>th</sup> Floor  
Philadelphia, PA 19107  
For this or other locations call  
800-321-9999

**Bennett, Richard I. MD**  
*Neurology*  
Katz Bennett Neurology Associates  
50 Township Line Road 101  
Elkins Park, PA 19027  
215-379-4300

**Queenan, Joseph MD**

Temple Hospital  
*Neurosurgery*  
3401 North Broad Street  
Zone C Room 540  
Philadelphia, PA 19140  
215-707-7200

**Wills Eye Hospital**

*Ophthalmology*  
840 Walnut Street  
Philadelphia, PA 19107  
215-928-3000

**Thoder, Joseph MD**

Temple Orthopedic & Sports Medicine  
*Orthopedic and Hand Injuries*  
3401 N Broad St  
5<sup>th</sup> Floor Outpatient Building  
Philadelphia, PA 19140  
215-707-2111

**Durable Medical Equipment - Please contact One Call Care Management at (800) 848-1989  
Express Scripts Pharmacy Program – for your local Express Scripts Pharmacy call (800) 897-9470  
In the event another provider is needed, contact PMA Management Corp. at (888) 476-2669**

- You must continue to visit one of these persons listed above, if you need treatment, for ninety (90) day from the date of your first visit. If you do not, your employer may not be required to pay these services.
- After this ninety (90) day period, if you still need treatment and your employer had provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice, or your employer may not be required to pay for these services.
- Your bills will be paid for IF: your licensed physician or practitioner of the healing arts files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.
- If no list is provided as above, you may go to a licensed physician of practitioner of the healing arts of your choice.
- If one of the persons listed above refers you to another licensed specialist, the panel physician will recommend an approved provider.
- If you are faced with a medical emergency, you may secure assistance from a hospital or physician or practitioner of the healing arts of your choice.

**Name:** School District of Philadelphia

**Address:** 440 North Broad Street, 3rd Floor Philadelphia, PA 19130

**Generated:** 11/20/19

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

This material is provided for informational purposes only and is not meant to be legal advice. Any person reading or otherwise using the information contained herein acknowledges that the information is provided as a service and is not authorizing any specific treatment or course of treatment. Further, use of any provider listed does not verify or confirm coverage under the Workers' Compensation Act and PMA is not responsible for any losses incurred as a result of any person relying on this information.

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# Workers' Compensation Temporary Prescription ID Card

## »» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

## Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

## »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

### Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury (enter in PA field in the format YYYYMMDD)

*For the following States, please utilize the below Group number: VT, NY, MA, RI, CT, PA, DE, MD, DC, VA, KY, NC, TN, SC, GA, AL, FL, MI, IN, IL, WI, MN*

### Express Scripts

ID #: \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

Group #: KVQA

Employee Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*For all other States, please utilize the below Group number:*

### Express Scripts

ID #: \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

Group #: L7EA

Employee Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## »» To the Supervisor: Please fill in the information requested for the injured worker.

### Employee Information

\_\_\_\_\_

First

M

Last

\_\_\_\_\_

Street Address or PO Box

\_\_\_\_\_

City

State

ZIP

### Employer Name

\_\_\_\_\_





## Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	Shaw's
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	Stop & Shop
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	Target
Bi-Lo	Fred's	Osco	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
BJ's Wholesale	Giant	Markets	The Pharm
Club	Giant Eagle	Pamida	Thrifty White
Brooks	Giant Foods	Park Nicollet	Times
Brookshire Brothers	Hannaford	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	Price Chopper	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
Costco	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	Rite Aid	Waldbaums
CVS	Keltsch	Rosauers	Walgreens
D&W	Kerr	Rx Express	Wal-Mart
Dahl's	Kmart	RXD	Wegmans
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	Sam's Club	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	

**NOTE:** This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.



EXPRESS SCRIPTS®