Synergy Claims
Reducing Costs, Managing Claim Outcomes

Workers' Compensation Injury Report Packet

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

Please fax or email these forms to:

724-704-7061 Attention: Claims Department

newclaim@synergyinsurance.com

Synergy utilizes a 24-7 triage nurse through Genex ClinicalCare24 for injuries that are not life, limb or eyesight threatening.

Genex ClinicalCare24

genex
AN ENLYTE COMPANY

1-833-203-2756

Or use QR Code to connect automatically.

24 HOURS PER DAY / 365 DAYS PER YEAR

Instructions for Supervisor during Nurse Triage:

- Provide a secure area for the Injured Worker to speak with the nurse.
- Please inform the nurse of any language needs: bilingual nurses for English and Spanish are available. Other languages: the nurse will bring in an interpreter prior to speaking with the Injured Worker.
- The nurse will ask questions to rule out an emergent situation. If the nurse does assess a life, limb or eyesight threatening situation, they may request assistance in getting Emergency Medical Services.
- The nurse will complete an assessment and derive at a medical care or self-care disposition.
- The nurse will ask the Injured Worker to place the manager back on the phone. The nurse will communicate the instructions that were given to the Injured Worker.
- If the Injured Worker needs to go for medical care, the nurse can offer to provide the Pharmacy phone number (866-429-1116) to the Injured Worker. The Injured Worker will have to take the temporary pharmacy card in this packet to the pharmacy to fill any prescriptions.

If you choose to call ClinicalCare24, be sure to still complete and send all the forms in this packet to the Synergy Claims Department.

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SUPERVISOR COVER SHEET

Supervisor Completes This Form

Please make sure and 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 their investigation.

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 their primary language.

What language does the employee speak in their 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: newclaim@synergyinsurance.com

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SUPERVISOR INCIDENT INVESTIGATION FORM

Supervisor Completes this Form

SOS Safety Solutions
When Safety Matters, SOS Delivers

Laurel Highlands School District

INJURED EMPLOYEE INFORMATION:

Name & Job Title: _____

Type of Injury: _____

DETAILS OF INCIDENT:

Incident Date: _____ Incident Time: _____ Department / Location: _____

INCIDENT INVESTIGATION:

Description of the Incident: Go to the scene of the incident and recreate it with the Injured Employee

_____

_____

_____

Investigation Checklist: Please submit copies of any evidence below to Synergy

- Is there surveillance footage of the incident? ☐ Yes ☐ No Comments: _____
- Are there photographs of the incident scene? ☐ Yes ☐ No Comments: _____

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: _____

_____

Supervisor Name: _____ **Phone:** _____ **Email:** _____

Injured Employee Signature: _____ Date: _____

Department Supervisor's Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

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WITNESS STATEMENT

Witness Completes this Form, if applicable

Employer: Laurel Highlands School District

Name: _____

Address: _____
City State Zip Code

Phone: _____

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.

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

_____ _____
Signature of Witness Date

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Laurel Highlands School District

Employee Incident Report

Injured Employee Completes this Form

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: _____

☐ I hereby **ACCEPT** to receive medical treatment. ☐ I hereby **DECLINE** to receive medical treatment.

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

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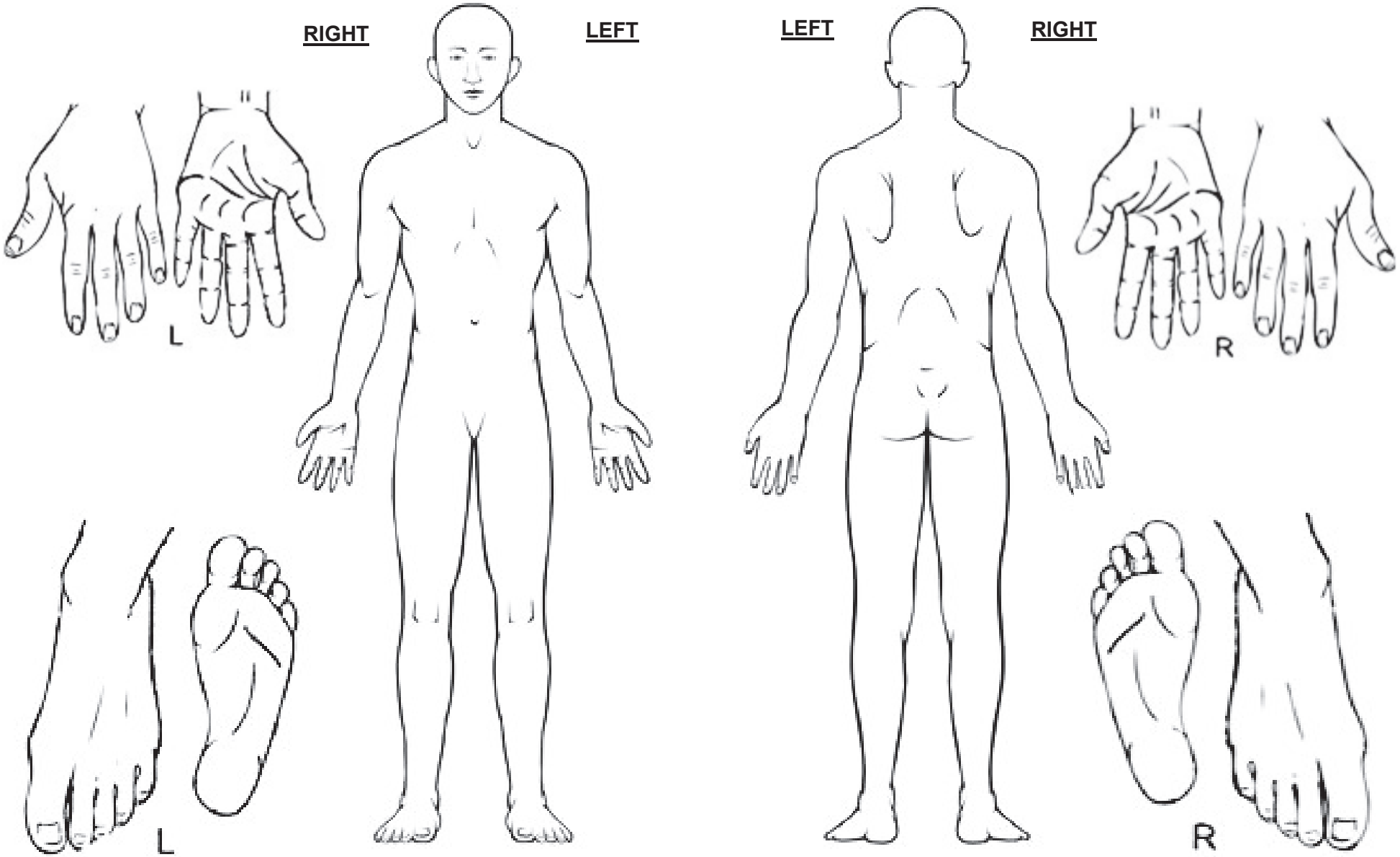
Pain Diagram

Injured Employee Completes this Form

Injured Employee: _____
Date of Injury: _____
Signature of Employee: _____
Date of Diagram: _____

Please draw a circle around the injured body part



Synergy Claims
Reducing Costs, Managing Claim Outcomes

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

Injured Employee Completes this Form

Employer: Laurel Highlands School District

Injured Employee: _____

Date of Injury: _____ Date of Birth: _____ SSN: _____

I authorize any licensed physician, medical practitioner, pharmacist, psychiatrist, psychologist, or other mental health care provider, hospital, clinic, or other medical or medically-related facility, insurance or reinsuring company, or employer having information available as to medical history, diagnosis, treatment, and prognosis to give any and all such information for which I am submitting a workers' compensation claim, to Synergy Comp Insurance, or to its legal representative.

Specifically, I am authorizing Synergy Comp, or it's legal representative, access to any and all records, including but not limited to, consultation reports, diagnostic reports, discharge summaries, emergency department reports, operative reports, progress notes, physician and/or nurse notes, etc. This document is pre-authorization for release of any and all subsequent dates of medical service.

I may later revoke this authorization by notifying an authorized representative of Synergy Claims in writing of my desire to revoke use of this authorization. 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 information supplied may be subject to re-disclosure with the context of my workers' compensation claim and would then no longer be protected by federal privacy regulations.

I understand the information obtained by use of the authorization will be used to determine eligibility for insurance benefits. Any information obtained through this authorization will be released as necessary for the processing of my claim, including any proceedings arising out of my claims.

I know that I may request a copy of this authorization.

Since this authorization is being provided regarding a workers' compensation claim, HIPAA is not applicable to this request. I agree that a photographic copy of the authorization shall be as valid as the original.

I agree this authorization shall be valid during the pendency of my claim. This authorization is not valid beyond one year after the date of execution.

_____ _____

Injured Employee Signature

Date
(expires one year after the above date)

Synergy Claims
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Panel Acknowledgement

Injured Employee Completes this Form

NOTICE: Medical Treatment Rights and Duties
PENNSYLVANIA

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 the following location 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.

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 and date one):

TIME OF HIRE: ☐ **WHEN I WAS INJURED:** ☐ **OTHER**: _____

Injured Employee Name: _____

Injured Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

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

Injured Employee Completes this Form

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 Injured Employee: _____ Date: _____

Synergy Claims
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SOS Safety Solutions
When Safety Matters, SOS Delivers

Accident Repeater Policy

Injured Employee Completes this Form

Policy Statement

It is the policy of Laurel Highlands School District that we provide to our employees a safe work environment. It is the belief of Laurel Highlands School District that accidents are preventable and that when both management and the work force work together to minimize workplace exposures and practice safe behavior, life and limb can be preserved.

In the unfortunate event that a workplace injury occurs to an employee due to unsafe behavior on the part of the injured employee's own actions, Laurel Highlands School District will take the following measures to prevent a re-occurrence by the same employee:

1. The appropriate management staff member will review with the employee how the accident investigation identified the cause of the accident as unsafe behavior.
2. Management will then discuss with the employee the appropriate safe work practice expected of the employee to fulfill the task accident free in the future.
3. Both the employee and the management staff member will form an agreement by filling out the Acknowledgement & Confirmation of the Accident Repeater Program.

If an employee has a second accident that occurs due to another unsafe act then management and the employee will follow the same three steps outlined above. However, this time the employee will be informed that this is their second unsafe act that resulted in an injury during their employment. It is imperative that employees are properly instructed and retrained by management following each and every accident, especially those that are caused by unsafe behavior by the injured employee.

In the event an employee sustains three or more work related injuries due to their own unsafe behavior, regardless of the time span between injuries, all of the steps outlined above will be executed again by the injured employee and the appropriate management staff member. It is the policy of Laurel Highlands School District that safe work behavior is a condition of employment and unsafe acts may result in termination.

Employee awareness to work safely is the goal of this policy as well as ensuring that management staff members are exercising their responsibility to prevent unsafe employee behavior.

_____ _____
Injured Employee Signature Date

_____ _____
Employer Representative Date

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SOS Safety Solutions
When Safety Matters, SOS Delivers

Accident Repeater Acknowledgement & Confirmation

Of Incident Repeater Policy Implementation

Injured Employee & Supervisor Completes this Form

This form is to confirm that Laurel Highlands School District has implemented and posted the Accident Repeater Policy. The purpose of the Accident Repeater program is to:

1. Identify why incidents are occurring and to implement remedial procedures
2. It is intended to provide a means of discussing incidents with those who have been involved with several incidents over a period of time.

Agreement: A discussion between management and the injured or affected employee has been completed to determine root cause and corrective action. Acceptable corrective actions are: counseling, redesigning job tasks and retraining.

Please print or type Corrective Action to be taken:

_____

_____

_____

_____

_____

_____

_____ (Employee Name), has been made aware of the Accident Repeater Policy & Program and agrees to implement and comply with said policy. By signing below, I understand that I must perform my job with the highest level of personal safety awareness and to stay **Incident free.**

Injured Employee's Signature: _____ Date: _____

Management Signature: _____ Date: _____

PriorityRx Prescription Payment Authorization Form

Injured Employee takes to Pharmacy

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

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MEDICAL AND BILLING INFORMATION

Injured Employee takes to Physician

EMPLOYER, please complete:

Name of Employee/Patient: Last:	First:
Date of Injury:	SSN (last 4):
Name of Employer: Laurel Highlands School District	

BILLING INFORMATION:

Insurance Type: Worker's Compensation
Insurance Company: Synergy Claims Management Company

Billing Submission Mailing Address: Rising Medical Solutions Attn: Synergy Comp Bill Review PO Box 542 Milwaukee, WI 53201	E-Billing via DataDimensionsEDI: www.datadimensions.com/risingms Synergy Payor ID: LV608
Bill Submission Fax Number: 866-767-3290 Attn: Synergy Comp Bill Review	Rising Customer Success Phone Number: Rising Medical Solutions, Inc. 866-274-7464

APPROVED VENDOR INFORMATION:

Durable Medical Equipment	SMS National	Phone: 800-404-9761 Fax: 888-404-9762
Pharmacy Benefit Manager	Corporate Pharmacy	Phone: 866-429-1116

AUTHORIZED PHYSICIAN, please complete:

Provider Name:	Date of Visit:
Diagnosis:	

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately, no restrictions.
- ☐ May resume work immediately with the following restrictions:
  - Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - Light work (lifting less than 20 pounds)
  - Medium work (lifting less than 50 pounds)
  - Heavy work (lifting less than 100 pounds)
- ☐ He/she is released to work:
  - _____ hours per day
  - His/her normal shift
- ☐ He/she may return to work at full duty on (date) _____
- ☐ He/she has a return appointment on (date) _____

Please indicate any referrals that are required: _____
_____

_____ _____ _____
Physician's Signature Date Physician's Name (type or printed)