# Grand River Insurance Agency

## Workers' Compensation Claim Kit – Pennsylvania

## Table of Contents

Page 3 – PA Claims Kit Introductory Letter

Page 4 – GRIA Requirements for PA Posting Notices

Page 5 – Workers' Compensation Notice

Page 6 – Employees' Rights and Duties

Page 8 – PA First Report of Injury

Dear Policyholder:

Thank you for placing your workers' compensation coverage with Grand River Insurance Agency (GRIA). We look forward to working with you to fulfill all your workers' compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers' compensation requirements for your state (i.e., posting notices, compliance laws, etc.).

Please utilize the documents included to collect valid information regarding the injured employee and incident and send the documents in when reporting the claim or upon request.

All new claims can be reported to claims@grandriverservices.com. Please email a completed first report of injury form ("Workers' Compensation Claim Form") along with a brief message describing the claim.

Pennsylvania state law recommends employers report every industrial injury or occupational disease claim to their workers' compensation carrier as soon as possible or within 5 days of employer knowledge of injury. State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury of illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of "medical control" and a significant increase in the potential claim cost.

We will attempt to contact you and the injured worker within 24 hours of receiving the First Report of Injury.

Questions regarding your insurance policy or coverage should be directed to your Grand River agent. We thank you for choosing Incline Casualty Company as your workers' compensation carrier and look forward to providing you superior customer service and compassionate care for your injured workers.

## Workers' Compensation Posting Requirements

**Workers' Compensation Notice Posters (LIBC-500 REV 09-22)**

- Post in one or more conspicuous places at all business locations

**To complete this form (LIBC-500 REV 09-22), please enter the following information in the spaces provided:**

- Your company name
- Date you posted the notice
- Your agent's phone number

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

# REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

**Employer Name:** _____ **Date Posted:** _____

**IF INSURED:**
(Complete all applicable spaces)

Name of Insurance Company: Incline Casualty Company
Address: 13215 Bee Cave Parkway
Building B, Suite 150, Austin, TX 78738
Telephone Number: _____

Insurer Code: 11090

**IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:**
(Complete all applicable spaces)

Name of TPA (Claims administrator): Grand River Services
Address: PO Box 1370 Marco Island, FL 34146
Telephone Number: (517) 290-7387

**IF SELF-INSURED:**
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____
Address:
Telephone Number: _____

Insurer Code: _____

**IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:**
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____
Address:
Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

| Employer Information Services | Claims Information Services | Hearing Impaired | Email |
|---|---|---|---|
| 717.772.3702 | toll-free inside PA: 800.482.2383<br>local & outside PA: 717.772.4447 | PA Relay 7-1-1 | ra-li-bwc-helpline@pa.gov |

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-500 REV 09-22
**WC7826h** (09-22) Wolters Kluwer | Uniform Forms

## *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.

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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.

# Workers' Compensation Claim Form

**Instructions:** Complete the claim form and submit it to the agency workers' compensation service representative for entry to SAP (or the FROI system for independent agencies) and submission to Inservco Insurance Services, Inc., telephone number 800.356.0438. Codes are listed on the reverse side of this form.

## Basic Data:

| Date of Report | Date of Injury | Personnel or Soc Sec Number | Injury Type ☐Inj Leave ☐Heart&Lung ☐Act 632/534 ☐Other |
|---|---|---|---|
| | | | |

## Employee Information:

| Employee Last Name | Employee First Name | M.I. | Suffix | Date of Birth | Gender ☐M ☐F |
|---|---|---|---|---|---|
| | | | | | |

| Employee Home Address | City | State | Zip + 4 |
|---|---|---|---|
| | | | |

| Residence County | Home Telephone Number | Married ☐Y ☐N | Number of Dependents | Employment Status |
|---|---|---|---|---|
| | | | | |

## Employer Information:

| Agency Number | Agency Name | Job Classification | Date of Hire |
|---|---|---|---|
| | | | |

| Org Code | Organization Name | Name of Supervisor | Work Telephone Number |
|---|---|---|---|
| | | | |

| Work Location Address | City | State | Zip + 4 | County |
|---|---|---|---|---|
| | | | | |

## Injury Date Information (enter times as military time):

| Time of Injury | Date of Death | Date Employer Knew | Shift Start Time | Type of Claim ☐Incident Only ☐Medical Only ☐Lost Time > 7 Days |
|---|---|---|---|---|
| | | | | |

| Last Full Day Worked | Date Disability Began | Date Returned to Work | At Same Wages? ☐Y ☐N | Occur During Overtime? ☐Y ☐N |
|---|---|---|---|---|
| | | | | |

## Injury Description Information:

| Injury on Employer Premises? ☐Y ☐N | If not in PA, list state | If not on premises, list address of accident |
|---|---|---|
| | | |

| Cause Code | Cause of injury additional information |
|---|---|
| | |

| Injury Type Code 1 | Injury Type Code 2 | Type of injury additional information and severity |
|---|---|---|
| | | |

| Body Part Code 1 | Body Part Code 2 | Body part affected additional information (example, left, right, upper, lower, etc.) |
|---|---|---|
| | | |

List all equipment, materials or chemicals employee was using when accident or illness occurred

Describe how injury or illness or abnormal health condition occurred. Describe the sequence of events and include any objects or substances directly responsible. Use abbreviations and short statements to include who, what, where, why and how. The what shall be the job assignment the employee was performing when injured.

| Any tools involved? ☐Y ☐N | Any mechanical defect? ☐Y ☐N | Unsafe act? ☐Y ☐N | Unsafe condition? ☐Y ☐N | Amputation? ☐Y ☐N |
|---|---|---|---|---|
| | | | | |

| Motor vehicle accident? ☐Y ☐N | Safeguards or safety equipment provided? ☐Y ☐N | Safeguards or safety equipment used? ☐Y ☐N |
|---|---|---|
| | | |

## Medical Information:

| Panel of physicians? ☐Y ☐N | Initial treatment | Medical provider name and address |
|---|---|---|
| | | |

## Employer Comments and Signature

Agree/disagree with description of injury? Other information about injury, including names and telephone numbers of any witnesses.

| Name of Supervisor completing form | Signature |
|---|---|
| | |

# Injury Type Codes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 01 | No Physical Injury | 03 | Hernia | 06 | Dust Disease, NOC | 76 | VDT-Related Disease |
| 02 | Amputation | 03 | Infection | 06 | Asbestosis | 77 | Mental Stress |
| 03 | Angina Pectoris | 03 | Inflammation | 06 | Black Lung | 78 | Carpel Tunnel Syndrm |
| 04 | Burn | 04 | Laceration | 06 | Byssinosis | 79 | Hepatitis C |
| 07 | Concussion | 04 | Myocardial Infarctn | 06 | Silicosis | 80 | Other Cumulative Inj |
| 08 | Hearing Loss | 04 | Poisoning-General | 06 | Rsprtry Dsrdrs | 90 | Mltpl Physical Inj |
| 10 | Contusion | 04 | Puncture | 06 | Poisn-Chem(non-mtls) | 91 | Mltpl Inj Phys/Psych |
| 13 | Crushing | 04 | Rupture | 06 | Poisoning-Metal | A1 | Animal Bite |
| 16 | Dislocation | 04 | Severance | 06 | Dermatitis | A2 | Abrasion |
| 19 | Electric Shock | 04 | Sprain | 06 | Mental Disorder | A4 | Human Bite |
| 22 | Enucleation/Removal | 05 | Strain | 07 | Radiation | A5 | Insect Bite/Sting |
| 25 | Foreign Body | 05 | Syncope/Fainting | 07 | Othr Occ Dse Inj NOC | A7 | Lyme Disease |
| 28 | Fracture | 05 | Asphyxiation | 07 | Loss of Hearing | A8 | Stab Wound |
| 30 | Freezing | 05 | Vascular | 07 | Contagious Disease | A9 | Gunshot Wound |
| 31 | Hearing Loss/Imprmnt | 05 | Vision Loss | 07 | Cancer | | |
| 32 | Heat Prostration | 05 | All Othr Spc Inj NOC | 07 | AIDS | | |

# Body Part Codes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10 | Multiple Head Injury | 12 | Larynx | 14 | Upr Bck Area(Thrcic) | 15 | Ankle |
| 11 | Skull | 12 | Neck - Soft Tissue | 14 | Lw Bck Area(Lbr&Lbo) | 15 | Foot |
| 12 | Brain | 12 | Trachea | 14 | Back/Disc | 15 | Toe(s) |
| 13 | Ear(s) | 13 | Mltple Upr Extrmtes | 14 | Chest(Ribs&Sft Tsue) | 15 | Great Toe |
| 14 | Eye(s) | 13 | Upr Arm(Clvcl-Scpla) | 14 | Sacrum and Coccyx | 16 | Lungs |
| 15 | Nose | 13 | Elbow | 14 | Pelvis | 16 | Abdomen incl Groin |
| 16 | Teeth | 13 | Lower Arm | 14 | Back - Spinal Cord | 16 | Buttocks |
| 17 | Mouth | 13 | Wrist | 14 | Internal Organs | 16 | Lumbar/Sacral Vertbr |
| 18 | Head - Soft Tissue | 13 | Hand | 14 | Heart | 16 | Artificial Appliance |
| 19 | Facial Bones | 13 | Finger(s) | 15 | Mltple Lwr Extrmtes | 16 | Insf Info 2 Prop Id |
| 20 | Neck - Multiple Inj | 13 | Thumb | 15 | Hip | 16 | No Physical Injury |
| 21 | Vertebrae | 13 | Shoulder | 15 | Upper Leg | 90 | Multiple Body Parts |
| 22 | Neck - Disc | 13 | Wrist(s) and Hand(s) | 15 | Knee | 91 | Bdy Sys/Mtpl Bdy Sys |
| 23 | Neck - Spinal Cord | 40 | Multiple Trunk | 15 | Lower Leg | | |

# Cause Codes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Burn, Heat Or Cold Expos.** | 15 | Cut/Inj By-Brkn Glas | 57* | Str/Inj By-Push/Pull | 80* | Strk-Obj Hndl by Oth | |

# Workers' Compensation Claim Form

| | |
|---|---|
| 2* | Burn-Cntct w/ Object |
| 3* | Burn-Temp Extremes |
| 1* | Burn-Acid Chem |
| 84* | Electrical Current |
| A3* | Heat Exhaust/Stroke |
| 4 | Burn-Fire or Flame |
| 5 | Burn-Steam/Hot Fluid |
| 11 | Burn-Cold Obj/ Subst |
| 7 | Burn-Welding |
| 8 | Burn-Radiation |
| 6 | Burn-Dst/Gas/Fms/Vpr |
| 14 | Brn-Abnml Air Presur |
| 9 | Burn-Miscellaneous |
| **Caught In or Beteween** | |
| 13* | Caught In/Betwn-Misc |
| 10 | Caught In-Machinery |
| 12 | Caught In-Obj Handld |
| 20 | Caught In-Collapse |
| **Cut, Puncture or Scrape** | |
| 16* | Cut/Inj By-Hand Tool |
| 18* | Cut/Inj By-Powr Tool |
| 19* | Cut/Inj By-Misc |
| 17 | Cut-Obj Liftd/Handld |
| **Fall or Slip** | |
| 25* | Fall/Slip-Diff Level |
| 29* | Fall/Slip-Same Level |
| 33 | Fall/Slip-On Stairs |
| 26 | Fall/Slip-Ladder |
| 28 | Fal/Slp-Into Opening |
| 32 | Fall/Slip-Ice/Snow |
| 27 | Fall/Slip-Liquid |
| 30 | Slip-Did Not Fall |
| 31 | Fall/Slip-Misc |
| **Motor Vehicle** | |
| 50* | Motr Veh-Misc |
| 46 | Motr Veh-Hit Fxd Obj |
| 45 | Motr Veh-Veh Colison |
| 48 | Motr Veh-Veh Upset |
| 41 | Motr Veh-Train |
| 47 | Motr Veh-Airplane |
| 40 | Motr Veh-Water Veh |
| **Strain or Injury By** | |
| 55* | Strn/Inj-Hold/Carry |
| 56* | Strain/Inj By-Lift |
| 58* | Strain/Inj By-Reach |
| 60* | Strain/Inj By-Misc |
| 54 | Strain/Inj By-Jump |
| 59 | Str/Inj By-Tool/Mach |
| 61 | Strain/Inj By-Throw |
| 97 | Strain-Repitv Motion |
| 53 | Strain/Inj By-Twist |
| **Strike Against or Step On** | |
| 70* | Step On/Strike-Misc |
| 65 | Step/Strik-Machine |
| 66 | Step/Strk-Obj Handld |
| 67 | Step/Strik-Scraping |
| 68 | Step/Strk-Statnry Ob |
| 69 | Step/Strik-Sharp Obj |
| **Struck By** | |
| 74* | Struck-Cowrker/Other |
| 75* | Struck-Fall/Fly Obj |
| 76* | Struck-Tool/Machine |
| 81* | Sruck/Inj By-Misc |
| 77 | Struck-Motor Veh |
| 78 | Struk-Machine In Use |
| 79 | Struck-Obj Handled |
| 86 | Inj By-Explosion |
| **Rubbed or Abraided** | |
| 94* | Rept Motn |
| 95* | Rub/Abraid-Misc |
| **Miscellaneous** | |
| A6* | Human Bite |
| 90* | Othr than Phys Caus |
| 52* | Strain/Inj By-Noise |
| 85* | Inj By-Anmal/Insct |
| 89* | Misc-Person/Crime |
| B1* | Microbiological Exp |
| 82* | Misc-Absorb/Ingest |
| A2* | Exp Misc Viral Infec |
| A4* | Exp to Skin Irritant |
| 87* | Forgn Matter in Eye |
| 98 | Misc-Cumulative |
| A5 | Gunshot Wound |
| A7 | Exposure to TB |
| A8 | Exp to Hepatitis B |
| A9 | Exposure to HIV |
| 99 | Misc-Other** |

* Recommended cause code

** Code should rarely be used