workpartners

Brentwood Borough School District - Pittsburgh (15227

YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy:WC200-2039798
Policy Effective Date:07/01/2025

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Please contact your Claims Adjuster for any specialty need not listed on this panel.

Name	Address	Scheduling	Area of Specialty
Concentra Medical Center - University Center (All Locations - Concentra.com)	120 Lytton Ave, Ste 275 Pittsburgh, PA 15213	412-621-5430	Occupational Medicine
Concentra Medical Center - West End (All Locations - Concentra.com)	1600 W Carson St, Ste 200 Pittsburgh, PA 15219	412-391-1137	Occupational Medicine
*UPMC GoHealth Urgent Care LLC - Brentwood (All Locations)	3516 Saw Mill Run Blvd Pittsburgh, PA 15227	412-884-0327	Urgent Care
*UPMC Trauma & General Surgery - UPMC Mercy	1400 Locust St, Ste 406 UPMC Mercy Hospital Pittsburgh, PA 15219	412-232-7161	General Surgery
*UPP Dept of Neurosurgery - UPMC Mercy	1350 Locust St, Ste 300 Pittsburgh, PA 15219	412-471-4772	Neurosurgery
*UPP Dept of Orthopaedic Surgery - South Side	3200 S Water St UPMC Rooney Sports Complex Pittsburgh, PA 15203	412-858-0385	Orthopedics
*Orthopaedic Specialists - UPMC - South Side	2310 Jane St, Ste 7100 Pittsburgh, PA 15203	412-748-7444	Orthopedics
*UPMC Vision Institute - Oakland	203 Lothrop St, Ste 718 Eye & Ear Institute Pittsburgh, PA 15213	412-647-2200	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.

Panel updated: 6/30/2025

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Report of Injury

Employer's Name and Address			Date
City, State, ZIP, County			Emp. Phone
Injured Worker's Last Name, First Name, Middle Initial			Recur/New Injury Date
Home Street Address			Home Phone No.
City, State, ZIP, County Marital Status			Time Work Began ☐ a.m. ☐ p.m.
Email Address			
Social Security Number		Date of Birth	Date of Hire
Occupation			
☐ Full-time ☐ Part-time	If Part-Time, Days Worked ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun		Name of Other Employer
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time ☐ a.m. ☐ p.m.	Date Reported	Time ☐ a.m. ☐ p.m.
Did incident occur on employer's premises? ☐ Yes ☐ No Where:			
Performing regular job at the time of incident? ☐ Yes ☐ No			
Losing time? ☐ Yes ☐ No Last day worked:			
Description of incident (who, what, when, where, how, and why):			
List of body parts injured:			
Prior injuries and with what employer:			
Treatment sought and with whom:			
Name and phone number of witnesses:			
Remarks:			
Reported by: Date: Time:			

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

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UPMCHP WC COMM IMJURY RPRT 17WP2017 (MJA) 10/9/17 PDF

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WORKERS' COMPENSATION CLAIMANT QUESTIONNAIRE

TO BE FILLED OUT BY EMPLOYEE

EMPLOYEE INFORMATION		
Name	Home Phone	
Address	Cell Phone	
City	State	Zip
Date of Birth	Social Security Number	
Do you currently have a driver's license? ☐ Yes ☐ No	Occupation_____ ☐ Full-time ☐ Part-time	
Briefly describe your job duties:		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Number of Dependents	
Weight	Height	
Are you ☐ Left-handed ☐ Right-handed?		
Do you participate in any sports, hobbies and/or recreational activities? ☐ Yes ☐ No If yes, please list below: _____ _____ _____		
Primary Care Physician Name	Primary Care Physician Phone	
Have you reported any Workers' Compensation claims in the past? ☐ Yes ☐ No If yes, please provide the approximant injury date(s), diagnosis and body part(s) injured: _____ _____ _____ Please list your past medical history, including non-work-related injuries, motor vehicle accidents, chronic illnesses and previous surgeries. Please include names of treating physicians: _____ _____ _____		

WORK / INJURY INFORMATION	
Name(s) of Current Employer(s)	
Phone Number(s) of Current Employer(s)	
Injury Date	Time Shift Started
Time of Injury	Date Injury Was Reported to Employer
Person To Whom Injury Was Reported	

Describe How Your Work Injury Occurred:

Were there any witnesses to your work injury? ☐ Yes ☐ No If yes, please list below:

Last Name	First Name		
Address	City	State	Zip
Home Telephone	Work Telephone	Job Title	
Last Name	First Name		
Address	City	State	Zip
Home Telephone	Work Telephone	Job Title	

MEDICAL INFORMATION

Provide date(s) of onset of current medical problem(s) and symptoms:

List body parts injured:

For all medical treatment and diagnostic testing, please list the date(s) of service and provider name(s):

Dates of Service	Provider Name

Please indicate the date of your next medical appointment and the physician's name:

Date of Appointment	Physician's Name

What are your current complaints?

Have you had prior problems or treated with a medical provider for this body part in the past? If yes, please explain and provide the name of the provider and dates of service.

WORK STATUS INFORMATION

Have you been medically released to return to work for this injury? ☐ Yes ☐ No If yes, please provide your date of release: _____

Were you released to ☐ Full duty ☐ Modified duty?

Have you returned to work according to your medical release? ☐ Yes ☐ No
If yes, please provide the date of your return: _____
If no, please indicate why you have not returned: _____
_____

FRAUD NOTICE

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____
Employee Signature Date

_____ _____
Supervisor Date Received

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WORKERS' COMPENSATION AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Employee's Full Name	**Claim Number**
Address	**Date of Birth**
City, State Zip Code	**Telephone Number**
Employer	

I hereby authorize the release of my protected health information (PHI) or other information relevant or potentially related to the injury or condition indicated below to WorkPartners, on behalf of UPMC Benefit Management Services, Inc. or UPMC Health Benefits, Inc., as applicable, its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.

Description of Injury or Condition: _____

Date of Injury or Condition: _____

Such disclosure may contain PHI or other information related to my Workers' Compensation medical condition or other condition(s) noted above, including, but not limited to, medical records, patient files, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings, provided all requests for this information are in writing.

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation, provided that such duration shall not exceed two years from the date of the signature on the following page.

I understand that WorkPartners may be required to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including but not limited to Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I certify that all of the information that I have provided is, to the best of my knowledge, true, correct, and complete.

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IMPORTANT INFORMATION ABOUT YOUR RIGHTS

- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing (*see* #2 on the next page), but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners.
- I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please return this completed and signed form by fax to 412-454-8717 or by mail to WorkPartners, PO Box 2971 Pittsburgh, PA 15230.

1. Type of records to be released (check all that apply):

☑ Inpatient
☑ Outpatient
☑ Diagnostic testing
☐ Other: _____

☑ Emergency department
☑ Physician/Office
☑ Physical therapy

Unless you check the box(es) immediately below, no information about alcohol/substance abuse, HIV/AIDS or behavioral health will be disclosed:

☐ **YES**, disclose information related to alcohol/substance abuse
☐ **YES**, disclose Information Related To HIV/AIDS
☐ **YES**, disclose Behavioral Health Information

2. I may revoke this authorization by notifying:

UPMC Insurance Services Division
Attn: Chief Privacy Officer
600 Grant Street
Pittsburgh, PA 15219
HealthPlanCPO@upmc.edu

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Employee	**Date of Employee's Signature**	**Employee's Date of Birth or Claim Number**

OR, if applicable –

Signature of Parent, Legal Guardian or Authorized Representative	**Date of Parent, Legal Guardian or Authorized Representative's Signature**	**Description of Authority to Act for the Employee (i.e., Parent, Legal Guardian or Authorized Representative)**

A copy of this completed, signed and dated form must be given to the member or other signator.

Official Use Only

Received	**Processed By**	**Log #**

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Provider Information: please use additional sheets of paper as needed

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Primary Care Physician Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Diagnostic Testing Provider: _____

Address: _____

_____

Telephone Number: _____

Patient Name (print): _____

Patient Signature: _____

Date of Signature: _____

MyMatrixx
By EVERNORTH

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Pennsylvania - Commercial

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

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

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: KYHA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number KYHA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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WORKERS' COMPENSATION INFORMATION

To All Employees:

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.

Benefits are required to be paid by your employer if 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. It is also required to be posted in any 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:

Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th Fl
Harrisburg, Pennsylvania 17121-0750
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)
certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file. Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230

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EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee' s Signature	Date
Employee' s Name (Print)	Employee Number
Employer	Department
Witness' Signature	Date

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDI-CAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KROGER
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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