Greensburg Volunteer Fire Department

Chief Tom Bell
416 South Main Street - Greensburg, PA 15601

http://www.gbgfire.org

GVFD steps to follow when you are injured

1. **Notify your Company Captain**
   -After notifying your Captain, you or your Captain MUST immediately notify the Chief and Medical Officer.

2. **Complete *"City Employee of GVFD Member Incident Report"***
   -This MUST be completed by the injured individual ONLY!
   - ALL sections of the Member Incident Report MUST be completed
   - See attached documents (SECTION A)

3. **Submit *"City Employee of GVFD Member Incident Report"* to the City Administrators office within 24 hours of the incident**
   - If the Incident occurs from 4:00 pm on Friday through Sunday, the Incident report must be submitted before the close of business the following Monday. If the incident occurs and the following day(s) is a holiday, the incident report must be submitted before the close of business on the next regularly scheduled business day.

4. **Designated Health Care Providers List.**
   - Injuries NOT requiring immediate emergency medical treatment MUST utilize a physician on this list.
   - See attached document (SECTION B)

5. **OPTUM Prescription Card**
   - If a doctor prescribes you ANY medication, you must provide this card to your pharmacy so that they can bill the worker's compensation insurance directly.
   - See attached document (SECTION C)

6. **While Under the Care of a Physician**
   - If you have NOT been released from the care of your physician you should NOT ATTEND any fire company/department related activities.

7. **Return to Work**
   - Once the injured firefighter has been released from the care of the physician (for the injury that has been reported), you must provide written documentation of the release to the City Administrator, Company Captain, and Department Medical Officer.

January 2023

Greensburg Volunteer Fire Department

Injured Firefighter

SECTION A

Fire Department Workers Compensation Directions

1. **Complete the incident report.**

-Numbers 1 through 10 MUST be completed. If you do not have an email address please write N/A. We cannot file a claim if any of this information is missing.

-Numbers 11 through 22 must be completed with as much detail as possible. If something is not applicable please write N/A. This alerts the City that it wasn't missed but is truly not applicable to your situation.

-Number 23 and 24, please mark the place of every injury, if you chose other please indicate in the blank space what the nature of the injury is.

-Number 26: It is ok if no one witnessed this, so this field can be marked N/A if there was no witness.

-Number 27: Please list any medical treatment sought, whether it is on the scene, your injury required an ambulance transport, and where you went. If you did not seek treatment but intend to, please make note of that and refer to the list of approved physicians that is attached.

-Once complete please sign the form and date it.

2. **Supervisor's Incident Investigation**

-This form is to only be completed by a supervisor, if there is not one available this form does not need to be completed.

3. **Incident Witness Statement**

-This form is only to be completed by a witness that saw the entire accident, if there are no witnesses, please discard this form.

4. **Designated Health Care Providers**

-This is the list of approved providers. If you need to schedule an appointment to be seen, please utilize only the doctors on this list.

-If the event is an emergency, you can go to any emergency room or Med Express Urgent care.

-When you arrive/schedule an appointment please tell the doctor/health care facility this is a comp claim, and if they need contact information they can call Angela at 724-838-4324.

5. **Optum Prescription Information**

-This card is to be used if a doctor prescribes you any medication, provide it to your pharmacy so that they can bill the worker's compensation insurance directly.

City of Greensburg

City Employee of GVFD Member Incident Report

(To be completed by injured individual ONLY)

1. Name of Injured :_____(City Employees stop and go to No. 8)

2. Fire Department Co. No._____ 3. How long have you been a member of the GVFD? _____

4. Street Address: _____ City: _____ State: _____Zip:_____

5. Date of Birth: _____ 6. Social Security No. _____ 7. Phone Number: _____

8. Email address: _____ 9. Married? _____ 10: No. of Dependents:_____

11. Date of Accident: _____ 12. Time of Accident: _____ 13. Lighting: _____

14. Weather Conditions: _____15: Who did you first report incident to and when? _____

16: What were you doing when accident occurred (in detail)? _____

_____

17. Were you trained to do this task? _____

18. How and why did the accident happen? _____

_____

19. What physical objects, tools, machines, structures or equipment were involved in accident? _____

_____

20. Were you wearing safety gear or protective clothing (please describe)? _____

_____

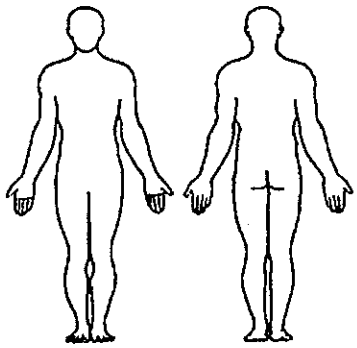
21. Could accident have been prevented? How? _____

Description of Injury

22. Describe injury (Pain, nausea, other symptoms) _____

_____

23. Parts of body affected (mark all that apply):



24. Nature of Injury (Check all that apply)

	Abrasion, Scrapes
	Broken Bones
	Bruise
	Burn (heat/chemical)
	Concussion
	Cut, Laceration, Puncture
	Dermatitis
	Hernia
	Sprain, Strain
	Other

24. Have you missed time at work due to this injury? _____ 25. When did you miss time at work? _____

26. Witness 1: _____ Witness 2: _____

Phone Number: _____ Phone Number: _____

27. Did you seek medical attention? _____ When? _____ Where? (facility or physician)_____

Signature of Employee/Fire Department Member: _____Date: _____

Signature of Supervisor: _____Date: _____

City of Greensburg

Supervisor's Incident Investigation for Report of Employee Injury

1. Name of Injured Employee: _____ Time Shift Began _____ Date of Incident _____

2. Date/Time Incident Occurred: _____ Date/Time Incident Was Reported to You: _____

3. Exact Location Incident Occurred: _____

4. Witnesses: Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

Description of Accident

5. Detail what the employee was doing, how he/she was doing it, and what physical objects, tools, machines, structures or equipment were involved in the incident.

_____

_____

_____

6. In your opinion, why did the incident occur? _____

_____

Prevention

7. What should be done and by whom to prevent recurrence of this type of incident?

   a. Physical Changes: _____

   b. Procedural Changes: _____

   c. Training Sessions: _____

8. What action are you taking to see that preventative changes are done? _____

_____

_____

_____

_____

Date of this report: _____ _____ _____

Signature of Supervisor Printed Supervisor Name

City of Greensburg

Incident Witness Statement

1. Name of Injured: _____

2. Name of Witness: _____ Phone No. _____

3. Home Address of Witness: _____

4. Location of Accident: _____

5. Date of Incident: _____ Time of Incident: _____a.m./p.m.

6. Lighting: _____ 7. Weather Conditions: _____

8. Describe how incident occurred: _____

_____

_____

_____

_____

_____

_____

_____

Date of this report: _____ _____ _____

Signature of Witness Witness received by (signature)

Greensburg Volunteer Fire Department

Injured Firefighter

SECTION B

AmTrust North America

An AmTrust Financial Company

Attached is a panel of Physicians for this address

KWC1305918 - 1 - City of Greensburg
416 S. Main Street
Greensburg, PA 15601

Date created: 01/10/23

Greensburg, PA 15601

Workers' Compensation Program: Designated Health Care Providers

The following procedures must be followed in case of work related injury or illness:

A. **Immediately report the injury to your supervisor.**
Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. Supervisors must promptly report injuries to the appropriate personnel office.

B. **Obtain medical care from a provider listed below.**

Concentra Medical Center
Occupational Medicine
Occupational Medicine Clinic
15 Freeport Rd Ste. 100
Pittsburgh, PA 15215
412-784-1678

St Clair Health
Occupational Medicine Clinic
2000 Oxford Dr
Bethel Park, PA 15102
412-942-7101

Bellicini, Christopher J., DO
Excela Health Orthopedics
Orthopedic Surgery
680 Pellis Rd
Greensburg, PA 15601
724-689-1970

WorkWell Physicians PC
Occupational Medicine Clinic
1 Monroeville Center
Monroeville, PA 15146
800-662-2400

MedExpress Urgent Care - Altoona
Urgent Care
Urgent Care Clinic
5126 State Route 30 Suite 300
Greensburg, PA 15601
724-836-3027

Richless, Lloyd, M.D.
Occupational Healthcare
Occupational Medicine
Occupational Medicine Clinic
251 7th St Ste 201-B
New Kensington, PA 15068
724-335-6662

Masterson, James N., DO
Orthopedic Surgery
410 Pellis Rd Ste 2A
Greensburg, PA 15601
724-689-1070

Optum
Available at any major pharmacy
PHARMACY
800-393-1398

Heads Up
For the nearest location, please call the toll free number.
DENTIST
855-443-9872

One Call Medical Diagnostics
Requires adjuster approval
DIAGNOSTICS
866-672-3064

One Call Care
Requires adjuster approval
PHYSICAL THERAPY
866-672-3064

Hospital
For Emergency Services, please go to the nearest hospital.
HOSPITAL
(FOR EMERGENCY SERVICES ONLY)

C. **Medical Emergency:**
If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. **If you choose to treat with an out of state provider, you may be subject to balance billing.**

E. **For medical treatment to be paid by your employer:**
1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

***For medical groups, all providers are eligible to render medical services.**

Greensburg Volunteer Fire Department

Injured Firefighter

SECTION C

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America — CARRIER/TPA

City of Greensburg — EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®