Brickstreet® StreetConnect Online Services Claim Filing

**Denotes Required Field*

Jurisdiction:	Policy Number:

Please note: The fields highlighted in grey are pre-populated in the online system.

What is your name?	What is your job title?
What is your telephone number?	What is your email address?

POLICY / DEMOGRAPHIC QUESTIONS

Are you the contact for this claim? ☐ Yes ☐ No	If no, who should we contact for additional information? *		
What is the contact's phone? *	What is the contact's email?		
Date of Injury/Date of Last Exposure: *			
What is your policy number?			
What is the employee's name?	First: *	Last: *	MI:
What is the employee's ID type? * ☐ Employment Visa Number ☐ Green Card Number ☐ Passport Number ☐ SSN		ID Number: *	
What is the employee's mailing address? Street/PO Box: *			
Zip: *	City: *	County: *	State: *
What is the employee's physical address? Street:			
Zip:	City:	County:	State:
What is the employee's primary telephone number?	What is the employee's alternate telephone number?		

WAGE / DEMOGRAPHIC QUESTIONS

What is the employee's date of birth? *	What is the employee's gender? * ☐ Male ☐ Female
What is the employee's marital status? * ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law	
What is the industrial /classification code? *	What is the job title? *
Description of employee's job and regular duties:	

WAGE / DEMOGRAPHIC QUESTIONS

What is the employee's hire date? *	What is the state of hire for this employee?
Is the employee? ☐ Owner/Part Owner ☐ Officer	Is the employee? ☐ Full-Time ☐ Part-Time ☐ Volunteer
What is the rate of pay for this employee? If full-time, enter daily rate _____. If part-time, enter hourly rate _____.	
How many hours did the employee work? If full-time, enter # of hours worked per day _____. If part-time, enter # hours worked per week _____ and # hours worked per day _____.	How many days per week did the employee work?
Is there any additional wage information not included in the daily rate? (Commissions, etc.)	
Is the employee continuing to receive full wages? ☐ Yes ☐ No	

INJURY QUESTIONS

What is the primary work location? * Name:			
Address:			
Zip:	City:	County:	State:
What is the reporting location?			
Did the accident occur on the employer's property? * ☐ Yes ☐ No			Department:
If no, where did the accident occur? Name:		Address:	
Zip:	City	County:	State:
Was this the employee's regular department? ☐ Yes ☐ No		In what department did the accident occur?	
How did the accident occur?			
Was safety equipment provided? ☐ Yes ☐ No		Was safety equipment used? ☐ Yes ☐ No	
If yes, what type?			
What was the injured body part(s)? *			
What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Not Applicable ☐ Right ☐ Upper			
What is the nature of the injury (sprain, strain, etc.)? *			
What is the type of injury? *			
Are you aware of a previous injury to this body part? * ☐ Yes ☐ No		If yes, please explain:	
Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ Yes ☐ No		If yes, please explain: *	
Are there outside activities or medical conditions that would affect this injury? ☐ Yes ☐ No		If yes, please explain: *	

INJURY QUESTIONS

List all others involved in the accident with contact information:

1.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			
2.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			
3.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			

List all witnesses to the accident or enter none:

1.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			
2.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			
3.	First Name:	MI:	Last Name:	
	Address:			
	Zip:	City:	County:	State:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? *	☐ On DOI?
What time did the accident occur? *	Who was notified of the accident?
When did the injured worker notify the employer? *	Did the claimant stop work? ☐ Yes ☐ No
What is the loss type? ☐ Incident Only ☐ Indemnity ☐ Medical Only ☐ Modified Duty No Wage Loss ☐ Modified Duty with Wage Loss	
What was the last date worked?	What time did the employee stop work?
Has the employee returned to work? ☐ Yes ☐ No	Date of return to work?
Did/will the claimant return to full duty? ☐ Yes ☐ No	Do you have transitional/modified work available? ☐ Yes ☐ No
Number of hours per week?	Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? ☐ Yes ☐ No	Name of medical provider?
What was the method of transportation? ☐ Air Ambulance ☐ Land Ambulance ☐ Other ☐ Personal Vehicle	
Do you require your employees to be drug tested? ☐ Yes ☐ No	If yes, when was the employee last tested?
Was an incident report completed? * ☐ Yes ☐ No	
Do you have any reason to question this injury? * ☐ Yes ☐ No	
Do you have any comments for the record?	

Medical Records Release

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution, or person that has any records or knowledge of my health, history, condition, or well-being

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____, _____
Claimant Name Claim Number

hereby authorize the use or disclosure of my individually identifiable health information described below to **BrickStreet Insurance, P.O. Box 3151 Charleston, WV 25322**.

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x-ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

__HIV/AIDS __Behavioral Health __Drug & Alcohol __Genetic History

I further authorize Recipient to use, disclose, or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on:____/___/____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ _____
Signature of Individual Date

_____ ____/_____/_____
Social Security Number Date of Birth

_____
Signature of Personal Representative, Estate Representative, or Guardian (Provide documentation of authority to act for individual

Brickstreet® INSURANCE

EMPLOYEE'S RIGHTS & DUTIES UNDER SECTION 306 (f.1) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

During the 90-day period, you may change from one designated physician or health care provider on the list to another physician or health care provider on the list, and the treatment will be paid for by the employer.

If the designated physician or health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider however, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

If the employer designated physician or health care provider recommends invasive surgery, you are permitted to obtain a second opinion from a non-designated physician or health care provider. Your employer will pay for the cost for this opinion. If this opinion differs from the opinion of the designated physician or health care provider and provides a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment however must be provided by a designated physician or health care provider for 90 days from the date of the visit to the non-designated physician.

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or 1-717-783-5421.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AN UNDERSTAND THE ABOVE RIGHTS AND DUTIES.

Employee Name	Employee Signature	Date
Supervisor Name	Supervisor Signature	Date

IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.

Supervisor Name	Supervisor Signature	Date

Brickstreet® INSURANCE

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

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 posted at _____ _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.l)(1)(i) 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.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

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 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 one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

Interboro School District

Your Workers' Compensation Insurance Carrier is:

BrickStreet Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

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. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, 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.
5. 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 physician's 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.
6. 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.

Name	Address	Phone	Area of Specialty
WORKNET Occupational Medicine (Multiple Locations)	1017 4th Avenue, Suite 200 Essington, PA 19029	610-521-6880	Occupational Medicine
Concentra Medical Centers (Multiple Locations)	7000 Holstein Avenue Philadelphia, PA 19153	215-365-7510	Occupational Medicine
Crozer Centers for Occupational Health (Multiple Locations)	196 West Sproul Road, Suite 210 Healthplex Pavilion I Springfield, PA 19064	610-328-8760	Occupational Health
Crozer Centers for Occupational Health (Multiple Locations)	Eight Morton Avenue, Suite 206 Taylor Hospital Medical Office Building Ridley Park, PA 19078	610-595-6811	Occupational Health
PA Rehab Associates, PC (Multiple Locations)	1501 Lansdowne Avenue, Suite 303 Darby, PA 19023	484-494-8646	Physiatry
Rothman Institute (Multiple Locations)	1118 West Baltimore Pike, Suite 302 Media, PA 19063	267-339-3776	Orthopedics
Rothman Institute (Multiple Locations)	3855 West Chester Pike, Suite 340 Newtown Square, PA 19073	267-339-3776	Orthopedics
Armando Mendez, MD Premier Orthopedics / Liberty Division	One Bartol Avenue, Suite 100 Ridley Park, PA 19078	610-521-8970	Orthopedics
Lawrence J. Mayer, MD	2100 Keystone Avenue, Suite 304 Drexel Hill, PA 19026	610-259-5007	General Surgery
Delaware Valley Surgical Associates	Delaware County Memorial Hospital 2100 Keystone Avenue, Suite 304 Drexel Hill, PA 19026	610-853-1662	General Surgery
Crozer Keystone General Surgery Associates	204 East Chester Pike Ridley Park, PA 19078	610-521-4833	General Surgery
Neurology Associates	CCMC Ambulatory Care Pavillion One Medical Center Blvd., Suite 533 Upland, PA 19013	610-874-1184	Neurology
Neurological Associates of Crozer Keystone Health Network	175 East Chester Pike Ridley Park, PA 19078	610-595-6272	Neurology
Moore Eye Institutes (Multiple Locations)	Healthplex II Springfield Hospital 100 West Sproul Road, Suite 100 Springfield, PA 19064	610-690-4900	Ophthalmology
Starer, Rizzo, & Ruffini Ophthalmology	Eight Morton Avenue, Suite 101 Ridley Park, PA 19078	610-521-2111	Ophthalmology
James R. Heller, DC	616 Baltimore Pike Springfield, PA 19064	610-328-5111	Chiropractic

Upper Darby Pain Management	152 Garrett Road Upper Darby, PA 19082	610-352-9901	Chiropractic

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Coventry DME Plus	Call Toll Free	1-877-203-9899	DME
Optum Pharmacy Network	Call Toll Free for Closest Location or go to www.cypresscare.com	1-800-419-7191	Pharmacy

Panel Date: 2/1/2017

10/14

BrickStreet

Physician Statement of Physical Capabilities

Return completed form to:

BrickStreet Insurance
P.O. Box 3151
Charleston, WV 25332-3151

Claimant Name	Claim Number	Date of Injury

Please complete this form after your examination of the patient. Indicate the patient's restrictions, if any, including modified hours, duties, environmental factors and any other information pertinent to this employee's healthy recovery and possible early return to work.

Medical Diagnosis

Work Postures (Work is performed in which postures? Please indicate frequency.)				
Standing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Sitting	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Walking	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Climbing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Kneeling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pushing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pulling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
	(6 – 8 hours a day)	(2 – 6 hours a day)	(0 – 2 hours a day)	

Please indicate the extent to which the employee can perform the following:
(N = Never, O = Occasionally, F = Frequently, C = Continuously)

Lifting / Carrying	N	O	F	C
10 lbs. or less				
11 – 20 lbs.				
21 – 40 lbs.				
41 – 60 lbs.				
61 – 100 lbs.				
Pushing / Pulling				
13 – 25 lbs.				
26 – 40 lbs.				
41 – 60 lbs.				
61 – 100 lbs.				
100+ lbs.				

Upper Extremities	**Yes**		**No**	
Simple Grasping	☐ R	☐ L	☐ R	☐ L
Pushing / Pulling	☐ R	☐ L	☐ R	☐ L

Activity	N	O	F	C
Bend				
Squat				
Kneel				
Twist / Turn				
Climb				
Crawl				
Reach Above Shoulder				
Type / Keyboard				
Driving				
Automatic				
Standard				

Operate foot controls or motor vehicles	**Yes**		**No**	
	☐ R	☐ L	☐ R	☐ L
Simultaneous	☐ Yes		☐ No	

Comments

Physician Name	Physician Telephone
Date released with above restrictions	Date released for full-duty work
Physician Signature	Date

OPTUM

Brickstreet

First Fill Information
BrickStreet

Dear Injured Worker,

Optum® has been selected by **BrickStreet** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Optum has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at cypresscare.com and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: 1-800-419-7191.

Estimado Trabajador(a) Lesionado(a),

Optum ha sido seleccionado por **BrickStreet** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Optum cuenta con una extensa red de farmacias al por menor. De la red de farmacias Optum incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en cypresscare.com y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: 1-800-419-7191.

First Fill Form: Complete and take to your pharmacy

Bin #: **010876** Group Number: **BRICKSTREET**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Pharmacy Help Desk: 1-800-419-7191.

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 14-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at **1-800-419-7191.**

Issuance of this letter does not constitute acceptance of your claim.