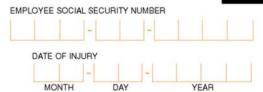
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY BUREAU OF WORKERS' COMPENSATION 1171 S. CAMERON STREET, ROOM 103 HARRISBURG, PA 17104-2501 (TOLL FREE) 800-482-2383 TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE



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NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.



STATEMENT OF WAGES (FOR INJURIES OCCURRING ON OR AFTER JUNE 24, 1996)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER -	DATE OF INJURY WCAIS CLAIM NUMBER MM DD YYYY
EMPLOYEE	EMPLOYER
First name	Name
Last name	Address —
Date of birth	Address
Address	City/TownState ZIP
Address	County
City/Town State ZIP	Telephone FEIN
County Telephone	
INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)	CONCURRENT EMPLOYMENT ONLY
Name	Check if Primary employer OR
Address	Concurrent employer
Address	
City/Town State ZIP	
County	
Telephone FEIN	
Contact	
NAIC code or Insurer code	
Insurer/TPA claim #	

INSTRUCTIONS

The Statement of Wages must be clearly completed in accordance with the Pennsylvania Workers' Compensation Act and uploaded in accordance with the provisions of the EDI Implementation guide when submitting certain EDI transactions. A copy must be sent to the injured employee.

The "average weekly wage" is used to determine the amount of weekly compensation wage-loss benefits payable under the Pennsylavania Workers' Compensation Act. A chart is available from the Bureau of Workers' Compensation to aid in determining the weekly compensation rate, online at www.dli.state.pa.us

CONCURRENT EMPLOYMENT

If the employee had more than one employer at the time of injury, a separate Statement of Wages form must be completed for each employer. Submit these forms together. Using #8 on the Primary Employer's form **only** (employer with whom the injury occurred): show the addition of the average weekly wages from all employers, show the combined average weekly wage to the right of the equal sign and show the appropriate workers' compensation rate. Check the Primary employer box for the Primary employer and the Concurrent employer box for all other employers.

Con	nputation	: Compute th	ne appropriate it	ems below for	the em	ployee to d	etermine th	e average w	eekly wa	ge.
			Wa	ne .		Weekly Board/ Lodging	Weekly Federal Reported Gratuities	Annua Bonus Incentivo Vacatio	s, e or	Average Weekly Wage
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Tele	phone									
Any ir	ndividual filin	g misleading or inco	mplete information kn	owingly and with the	e intent to o	defraud is in vio	lation of Section	1102 of the Penn	sylvania Wor	kers' Compensation Act,

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





WORKERS' COMPENSATION MEDICAL REPORT FORM

THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

Name of employee	
Name of employer	
Name of insurer	
WCAIS claim number	Date of birth
Employee SS# XXX-XX	Date of injury
WC ID number	
Date of report	
Provider name	
Provider address	
Contact person	Telephone

Health care providers shall complete and submit the appropriate HCFA billing form and needed documentation to the employer. If the employer is covered by an insurer, the appropriate billing form and documentation is to be sent to the insurer. The LIBC-9 form and required accompanying documentation shall be submitted within 10 days of commencing treatment and at least once a month thereafter, as long as treatment continues. If a provider does not submit the required medical reports in the prescribed format, the employer/insurer is not obligated to pay for such treatment until the required report is received by the employer/insurer.

Documentation shall include (where pertinent) claimant's history, diagnosis, description of treatment and services rendered, physical findings and prognosis including whether or not there has been recovery enabling the claimant to return to work with or without limitations, and specific restrictions, if any, regarding return to work. Bills for follow-up visits should include progress/office notes to support the diagnosis and codes billed.

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports specifically requested by the employer/insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as confidential by the employer/insurer. The employer/insurer shall not be liable to pay for treatment until the required documents have been provided.

Listed on the reverse are guidelines for the completion of billing forms and submission of records.

BILLING FORM GUIDELINES:

Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form, or any successor forms required by HCFA/CMS. Forms must be signed or typed with the name of the provider. Name and signature (if signature is used) must match.

Cost-based providers shall submit a detailed bill including service codes and rev codes consistent with the service codes and rev codes submitted to the Bureau of Workers' Compensation on the detailed charge master.

Until a health care provider submits bills on one of the forms specified above, employers/insurers are not required to pay for the treatment billed.

MEDICAL REPORT FORM GUIDELINES:

This form must be submitted within 10 days of initial treatment and monthly thereafter, and must be accompanied by documentation to support the billing.

Suggested supporting documentation:

Physicians — Office notes

Physical/Occupational therapists — Daily treatment records/notes with physician referral

Pharmacies — NCD#, amount dispensed, RX#

DME vendor — Medicare/HCPC code, certificate of medical necessity

Chiropractors — Treatment notes

Ambulance providers — Medicare codes, notes/reports

X-ray/MRI facilities — Reports

Lab Facilities — Test results

Anesthesia services — ASA code, base/time units, anesthesia record

 $Hospitals-Records\ from\ area\ providing\ the\ service\ (e.g.\ emergency,\ outpatient\ surgery...)$

Inpatient hospital admissions — H&P, discharge summary, operative report (if applicable) CORFs & Rehabilitation Centers — Daily treatment notes, including physician orders

Ambulatory surgery centers — Notes and reports

General for all providers: Use the most appropriate and specific HCFA/CMS coding on billing.

When using miscellaneous codes, include detailed description of services.

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