

AmeriHealth Casualty Services  
100 Corporate Center Drive  
Suite 101  
Camp Hill, PA 17011  
717.213.2990  
800.719.2889  
800.929.0534 fax



### What Happens If I Get Hurt At Work?

Even at the safest of workplaces, injuries can occur. Here's what to do if you are injured at work:

1. Notify your supervisor immediately. He/She will ensure that you receive medical care if you need it and will file a workers' compensation claim on your behalf.
2. For emergency care you should go to the closest emergency room. Any follow-up care should be provided by one of the approved facilities on your workers' compensation panel list. For non-emergencies, choose one of the panel doctors. If you do not have a panel list, see your supervisor or Human Resources.
3. According to Pennsylvania's Workers' Compensation Act, you must treat with a panel provider for the first 90 days. Any unauthorized treatment or treatment outside the panel will be your financial responsibility and may jeopardize your claim. After 90 days you may treat with a provider of your choice but you must notify your employer in writing within 5 days of the first visit or the treatment becomes your financial responsibility.
4. The panel physician will evaluate your injury and determine if it is safe for you to return to work. If you are not returned to work, notify your supervisor immediately.
5. You must keep scheduled appointments with your treatment provider. If, for any reason, you are unsatisfied with the care you are receiving, please call AmeriHealth at 1-888-871-3606. After regular business hours, call 1-800-393-7196. Our claims adjusters and medical case managers are available to discuss your claim and to ensure that you receive reasonable and necessary care for your work injury.

---

#### Acknowledgment

In compliance with Pennsylvania's Workers' Compensation Act, I acknowledge that I have been informed of my rights and have received a copy of the designated health care provider panel which was designed by AmeriHealth Casualty Services for my employer,

TOWNSHIP OF CUMRU

I understand that any work

(Name of Company)

related injury or illness is to be immediately reported to my supervisor and, with the exception of true emergency care, I am to treat with one of the providers on the panel for the first 90 days after my injury. I understand that if I treat outside this panel without proper authorization, my employer has the right to refuse payment for that care. Should I still require treatment after 90 days, I understand that I may choose a non-panel provider but that I must notify my employer within five days of the first visit to this provider. I understand that if surgery is recommended I may seek a second opinion with a physician of my choosing. If the second opinion differs, I may choose the course of treatment I wish to follow but that treatment is to be rendered by one of the panel providers if I am within the first 90 days after injury.

---

Signature

---

Date

## TOWNSHIP OF CUMRU

### WORKERS' COMPENSATION PROGRAM: DESIGNATED HEALTH CARE PROVIDERS

THE FOLLOWING PROCEDURE 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.**

<i>Provider</i>	<i>Address</i>	<i>Phone Number</i>	<i>Specialty</i>
1. Jonathan Dreazen, MD	WORKNET, 3225 North 5th Street Suite 4 Reading, PA 19605	610-939-2391	OCCUPATIONAL MEDICINE
2. Vera Guertler	Occupational Health Services @ Reading Hospital, 301 South Seventh Avenue Suite 2020 West Reading, PA 19611	610-988-8437	OCCUPATIONAL MEDICINE
3. David E. Nowotarski, DC	Nowotarski Chiropractic, 3443 Penn Avenue Sinking Springs, PA 19608	610-678-8600	CHIROPRACTIC
4. One Call Care Dental and Doctor	One Call Care Dental and Doctor, For the nearest location, please call the toll free number.	888-539-0577	DENTIST
5. Michael T. Brown, MD	Spring Ridge Medical Center, 2758 Century Boulevard Wyomissing, PA 19610	610-373-4151	GENERAL SURGERY
6. Moiz M. Carim, MD	Carim Eye & Retina Center Ltd., 2630 Westview Drive Wyomissing, PA 19610	610-376-1981	OPHTHALMOLOGY
7. John F. Perry, III, MD	1121 Penn Avenue Wyomissing, PA 19610	610-286-1660	ORTHOPEDIC SURGERY
8. myMatrixx	For the nearest location, please call the toll free number.	877-804-4900	PHARMACY
9. Select Medical / NovaCare	Select Medical / NovaCare, For the nearest location and to make an appointment, please call the toll free number.	800-770-6682	PHYSICAL THERAPY
10. RIN / One Call Care Management Company	RIN / One Call Care Management Company, For the nearest location and to make an appointment, please call the toll free number.	800-453-0574	RADIOLOGY
11. 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 below 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 health care 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:

ACS - CAMP HILL OFFICE  
AmeriHealth Casualty Services  
100 Corporate Center Drive, Suite 101  
Camp Hill, PA 17011  
1-800-719-2889

06/27/2013

**RECEIVED**  
JUL 02 2013

- For medical practice groups, all providers are eligible to render medical services

BY: RLC

PHONE (610) 777-1343

FAX (610) 796-0850

# TOWNSHIP OF CUMRU

BERKS COUNTY, PENNSYLVANIA  
1775 WELSH ROAD  
MOHNTON, PA. 19540

WWW.CUMRUTOWNSHIP.ORG

## INCIDENT REPORT FORM

DATE OF INJURY \_\_\_/\_\_\_/\_\_\_

NAME: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
COUNTY: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

EMPLOYEE:  
MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ NUMBER OF DEPENDENTS: \_\_\_\_\_  
MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OCCUPATION OR JOB TITLE \_\_\_\_\_

NCCI CLASS CODE (IF KNOWN) \_\_\_\_\_  
EMPLOYMENT STATUS \_\_\_\_\_

FT-FULL TIME    PT-PART-TIME  
SL-SEASONAL    VO-VOLUNTEER  
ZZ-OTHER

IF YOU ARE A VOLUNTEER, PLEASE PROVIDE SOC. SEC. NO. \_\_\_\_\_

EMPLOYER                    TOWNSHIP OF CUMRU  
STREET ADDRESS            1775 WELSH ROAD  
CITY, STATE, ZIP            MOHNTON, PA 19540  
PHONE                        (610) 777-1343

COUNTY \_\_\_\_\_ NAICS CODE \_\_\_\_\_

FULL PAY FOR DAY OF INJURY: YES \_\_\_\_\_ NO \_\_\_\_\_  
TIME EMPLOYEE BEGAN WORK: \_\_\_\_\_ TIME OF OCCURRENCE: \_\_\_\_\_  
LAST DAY WORKED \_\_\_\_\_ DATE DISABILITY BEGAN \_\_\_\_\_  
DATE EMPLOYER NOTIFIED \_\_\_\_\_ DATE RETURNED TO WORK \_\_\_\_\_  
DATE OF HIRE \_\_\_\_\_  
CONTACT NAME \_\_\_\_\_ CONTACT PHONE NUMBER \_\_\_\_\_

TYPE OF INJURY OR ILLNESS: \_\_\_\_\_

PARTS OF BODY AFFECTED: \_\_\_\_\_

CAUSE OF INJURY: \_\_\_\_\_

DID INCIDENT OCCUR ON EMPLOYER'S PREMISES: \_\_\_\_\_



LOCATION OF INCIDENT: \_\_\_\_\_  
\_\_\_\_\_

IF OUT OF STATE, SPECIFY STATE OF INJURY: \_\_\_\_\_

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED: \_\_\_\_\_

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED: \_\_\_\_\_

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED \_\_\_\_\_  
\_\_\_\_\_

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.  
\_\_\_\_\_  
\_\_\_\_\_

IDENTIFY THE DIRECT CAUSE, BUT DO NOT STOP THERE. CONTINUE YOUR ANALYSIS UNTIL YOU IDENTIFY THE ROOT CAUSES, ASK WHY UNTIL IT NO LONGER MAKES SENSE TO DO SO. THIS WILL HELP YOU TO IDENTIFY THE ROOT CAUSE.

INDIRECT OR ROOT CAUSES (CHECK APPROPRIATE BOX)

- HABIT (REPEATED BEHAVIOR WITHOUT CONSCIOUS THOUGHT, E.G., IMPROPER LIFTING)
- HABIT INTERFERENCE (UNANTICIPATED INTERRUPTION OF HABITUAL BEHAVIOR, E.G. SUDDEN LOUD NOISE)
- PHYSICAL OR MENTAL IMPAIRMENT (PHYSIOLOGICAL FACTORS SUCH AS FATIGUE)
- LACK OF KNOWLEDGE OR SKILL (ABSENCE OF NECESSARY INFORMATION, NO TRAINING, NEW EMPLOYEE, UNFAMILIAR JOB TASK)
- LACK OF POLICIES OR PROCEDURES (OR LACK OF ENFORCEMENT)
- BARRIERS (SAFETY VERSUS TIME, SAFETY VERSUS CONVENIENCE, SAFETY VERSUS COMFORT, ETC.)
- TRAPS (SPILLS, HOUSEKEEPING, CLUTTER, UNGUARDED/FAULTY MACHINERY, ETC.)
- CONFLICTING MOTIVATIONS (IMPROPER INCENTIVES, WORKING RELATIONSHIPS, LACK OF TEAM ENVIRONMENT, ETC.)

DIRECT CAUSE OR IMMEDIATE UNSAFE ACTS OR CONDITIONS REVEALED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXPLAIN THE DIRECT AND INDIRECT CAUSES LISTED ABOVE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ACTIONS NEEDED TO PREVENT RECURRENCE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSON OR PERSONS RESPONSIBLE FOR CORRECTIVE ACTION: \_\_\_\_\_

IF FATAL, GIVE DATE OF DEATH \_\_\_\_\_

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_  
STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INITIAL TREATMENT  NO MEDICAL TREATMENT  MINOR BY EMPLOYEE  CLINIC/HOSPITAL  
 PANEL PHYSICIAN  EMPLOYEE PHYSICIAN  EMERGENCY CARE  
 HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ POLICY PERIOD TO: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

HOSPITAL NAME: \_\_\_\_\_  
STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

POLICY/SELF INSURED NUMBER \_\_\_\_\_

WITNESS NAME \_\_\_\_\_ WITNESS PHONE NUMBER \_\_\_\_\_

WITNESS STATEMENT (INCLUDE DETAILS OF WHAT WAS SEEN OR HEARD AT THE TIME OF THE INCIDENT)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WITNESS NAME: \_\_\_\_\_  
WITNESS PHONE NUMBER \_\_\_\_\_

WITNESS STATEMENT (INCLUDE DETAILS OF WHAT WAS SEEN OR HEARD AT THE TIME OF THE INCIDENT)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSON COMPLETING THIS FORM:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATE PREPARED: \_\_\_\_\_

DESCRIPTION OF ACCIDENT/EMPLOYEE'S STATEMENT (DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DESCRIPTION OF INJURY OR PROPERTY DAMAGE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WORKERS' COMPENSATION FRAUD IS A CRIME PUNISHABLE BY A FINE UP TO \$50,000 AND/OR IMPRISONMENT UP TO SEVEN YEARS! FRAUD INCLUDES BUT IS NOT LIMITED TO:

- FAKED INJURY
- DELIBERATE INJURY
- PHONY MEDICAL OR TREATMENT BILLS
- NON WORK RELATED INJURY
- MISREPRESENTATION OF LOST WAGES OR LOST TIME

SUPRVISOR SIGN AND DATE \_\_\_\_\_

I CERTIFY THAT THE STATEMENTS MADE ON THIS DOCUMENT ARE TRUE AND ACCURATE TO THE BEST OF MY ABILITY. I ALSO UNDERSTAND THAT WORKERS COMPENSATION FRAUD IS A CRIME AND IS PUNISHABLE AS LISTED ABOVE.

\_\_\_\_\_  
SUPERVISORY ACKNOWLEDGEMENT, SIGNATURE & DATE

EMPLOYEE SIGN AND DATE \_\_\_\_\_

I CERTIFY THAT THE STATEMENTS MADE ON THIS DOCUMENT ARE TRUE AND ACCURATE TO THE BEST OF MY ABILITY. I ALSO UNDERSTAND THAT WORKERS COMPENSATION FRAUD IS A CRIME AND IS PUNISHABLE AS LISTED ABOVE.

\_\_\_\_\_  
EMPLOYEE ACKNOWLEDGEMENT, SIGNATURE & DATE

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME: ACS - CAMP HILL OFFICE, AMERIHEALTH CASUALTY SERVICES

STREET: 100 CORPORATE CENTER DRIVE, SUITE 101

CAMP HILL, PA 17011

PHONE: 1-800-719-2889

\_\_\_\_\_  
Completed by Human Resources

DATE RECEIVED BY HUMAN RESOURCES: \_\_\_\_\_

EMPLOYEES SOCIAL SECURITY NUMBER: \_\_\_\_\_

EMPLOYER FEIN: 23-6000288

SIC CODE: \_\_\_\_\_

CONTACT PERSON'S NAME: Peggy A. Carpenter 610-777-1343 ext. 110



## Employee's Acknowledgement of Physician Panel

### *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 **THE TOWNSHIP OF CUMRU'S BULLETIN BOARDS** for you to view. Also, you may get a copy of this list from **SUPERVISOR**. If you are injured at work or suffer an occupational illness, you have certain **RIGHTS** and **DUTIES** under Section 306(f.1)(1)(i) of the Worker's 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 or 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 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 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 listed 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 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



**AmeriHealth Casualty  
Workers' Compensation Prescription Information**

**Employer:** TOWNSHIP OF CUMRU

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	
Employee Name:	
Group#:	10602116
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

**Employee:**

AmeriHealth Casualty has partnered with *myMatrixx* to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

**IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900**

**Pharmacist:**

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900**



## Employee's Acknowledgement of Physician Panel

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 5 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 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 PRESENT TO ME AT (check one);

TIME OF HIRE     WHEN I WAS INJURED     OTHER

EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYER REPRESENTATIVE \_\_\_\_\_  
DATE \_\_\_\_\_

EMPLOYEE REFUSES TO SIGN BUT WAS PROVIDED A COPY OF THIS DOCUMENT



TYPE OF INJURY CODE 	PART OF BODY AFFECTED CODE 	CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN) 
-------------------------	--------------------------------	--

TYPE OF INJURY OR ILLNESS  
| | | | |

PARTS OF BODY AFFECTED  
| | | | |

CAUSE OF INJURY  
| | | | |

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF OUT OF STATE, SPECIFY STATE OF INJURY 	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	--	--

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH

MONTH	DAY	YEAR

INITIAL TREATMENT:

- NO MEDICAL TREATMENT
- MINOR BY EMPLOYEE
- CLINIC / HOSPITAL
- PANEL PHYSICIAN
- EMPLOYEE PHYSICIAN
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME:	LAST NAME:
STREET	
CITY	STATE ZIP

HOSPITAL NAME:

STREET
CITY STATE ZIP

POLICY PERIOD FROM:

0   4	-	1   3	-	2   0   1   1
MONTH		DAY		YEAR

POLICY PERIOD TO:

0   4	-	1   3	-	2   0   1   2
MONTH		DAY		YEAR

POLICY/SELF INSURED NUMBER:

1   0   0   0   0   0   0   1   4   8   5   1   1   1   1
---

WITNESS FIRST NAME

	WITNESS PHONE NUMBER
	-

WITNESS LAST NAME

--

PERSON COMPLETING THIS FORM:

NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:
STREET
CITY STATE ZIP
BUREAU CODE: FEIN:

DATE PREPARED

MONTH	DAY	YEAR



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.

AmeriHealth Casualty Services  
100 Corporate Center Drive  
Suite 101  
Camp Hill, PA 17011  
717-213-2990  
800-719-2889  
800-929-0534 fax



### Authorization to Release Medical Information

I hereby authorize any physician, nurse or other health care professional who has attended me, or any hospital at which I have been confined to furnish to AmeriHealth Casualty Services or an authorized representative, any and all information which may be requested regarding my physical or mental condition and treatment rendered therefore and, if necessary, to allow them or any physician appointed by them to examine any x-rays take of me or records regarding my physical or mental condition or treatment.

A photocopy of this instrument may be used instead of the original.

### La Autorización a Soltar a Informacion Médico

Por este medio autorizo a cualquier médico, cualquiera enfermera u otro profesional de cuidado de la salud que me ha asistido a mí, o cualquier hospital en el cual he estado recluido para proveer para AmeriHealth Casualty Services o un representante autorizado, cualquier información que puede ser demandado referente a mi condición física o mental y que mi tratamiento dado por esto y, si necesario, a permitirlos a ellos o cualquier médico señalado por ellos a examinar cualquier tome radiografías de mí o los registros estimando mi condición física o mental o el tratamiento.

Una fotocopia de esta forma puede ser usada en lugar del original.

_____	_____
Date	La fecha
_____	_____
Employee's Name (Print)	Nombre del Empleado (la Impresión)
_____	_____
Employee's Signature	Signatura del Empleado
_____	_____
Employee's Date of Birth	Fesha de Nacimiento del Empleado
_____	_____
Employee's Social Security Number	El Numero de Seguro Social del Empleado
_____	_____
Employee's Home/Cell Phone Number	El Número de Teléfono de Casa/Celular del Empleado