

**CITY OF PITTSBURGH: NOTICE CONCERNING MEDICAL TREATMENT
FOR YOUR WORK RELATED INJURY OR ILLNESS**

The City of Pittsburgh (hereinafter "employer") has selected the following list of physicians and other health care providers (hereinafter "listed panel provider"). **Should you require medical attention for your work related injury or illness, you must select from one of the listed panel providers. If you require ongoing treatment you must continue to visit one of the providers listed below for ninety (90) days from the date of your first visit.**

This list is posted at your department's main office for you to view. Also, you may obtain a copy of this list from UPMC Work Partners Claims Management Services at 1-800-633-1197.

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

You have the RIGHT to choose which of the listed panel providers will treat you for your work injury or illness.

You have the RIGHT to switch among any of the listed panel providers when you receive treatment; and if a listed panel provider refers you to a physician not on your employer's list, you have the right to receive treatment from the referral physician.

You have the RIGHT to receive treatment at the closest Emergency Department for your initial care. However, non-emergency treatment and follow up care must be given by a listed panel provider.

If you seek treatment for your work injury or illness from a physician of your choice, your employer may not have to pay for this medical treatment during this 90-day period.

If a listed panel provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any physician of your choice. The City shall pay the cost for the second opinion provided that the physician chosen is Board certified in the specialty area for which the surgery is recommended. If that opinion is different from the opinion of the listed panel 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 panel provider for a period of 90 days after the date of your visit to the provider of the second opinion. **Therefore in this situation you may be required to treat with listed panel provider for up to 180 days.**

You have the DUTY to visit one or more of the listed panel 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.

IMPORTANT: The list of panel providers is on the reverse side of this form.

MEDICAL TREATMENT AFTER THE FIRST 90 DAYS

You have the RIGHT to receive treatment from any physician of your choice, whether or not they are a listed panel provider. 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 of your choice.

You have the DUTY to notify your employer if you receive treatment from a physician of your choice. You must notify your employer within 5 days of the first visit to any physician that is not a listed panel provider. The employer may not be required to pay for treatment received until you have given this notice.

By signing this form I have been informed of and understand my medical treatment rights and duties with regard to work-related injuries and occupational illnesses. My refusal to sign this form does not release me of my medical treatment duties regarding work-related injuries and occupational illnesses. This notice was presented to me at (check one):

TIME OF HIRE

WHEN INJURED

Employee Print: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

(Give a copy of this two sided form to the employee; send original to the Department of Personnel & C.S.C.)

