

Workers' Compensation

Panel Physicians Form



The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work related injury. If you do not use one of these physicians for your work related injury, you may be responsible for the cost of medical care.

Please select a physician from this Panel, complete and sign this form and return it to your supervisor. The supervisor should immediately return this form to **MC INNOVATIONS (MCI) at P.O. Box 1140, Richmond, VA 23218-1140. Phone 804/649-2288. Fax 804/371-2556 or via e-mail to covimaging@sedgwick.com.**

Please choose from the following list by writing the physician's name and signing the form. Return the form to your supervisor for filing with the claim application.

INITIAL CARE

1. Concentra Medical Center
Name
801 Poindexter St. Ste. 218 & 226
Address
Chesapeake, VA 23324
757-494-1688
Phone

2. NowCare Medical Center- Indian River
Name
6632 Indian River Rd
Address
Virginia Beach, VA 23464
757-424-4300
Phone

3. Patient First Primary & Urgent Care Taylor Road
Name
2425 Taylor Rd
Address
Chesapeake, VA 23321
757-215-1800
Phone

OTHER - Pharmacy Benefits

4. **Concentra Telemed**
Dr. Shauna Stupart
(877) 861-1251
Patient Access:
www.concentratelemed.com **Employer Information:**
www.concentra.com/telemedicine
telemed@concentra.com

Alius Health - First Fill Pharmacy Benefits Member ID: ALIUS + last 4 digits of patient SSN
Person Code: 01
RxGroup #: ALHFF03012021
RxBIN/IIN: 610729
RxPCN: ALIUS
ATTENTION PHARMACISTS: Please process prescriptions through Script Care. For questions, please call Alius Health at 740-661-4463. 800-563-8438

Employee

By signing this form, I release all medical information to MC Innovations. All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected:

Dr. _____ to provide me with medical care for my work related injury.

Signed: _____ Date: _____
NAME

Printed: _____ Date of Injury: _____
NAME

Employer

This is a Commonwealth of Virginia employee and authorized to treat with the above selected physician (facility).

Name: _____ Date: _____

Title: _____ Signature: _____

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St

Richmond, Virginia 23219

1-877-664-2566

www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

Effective Date: 2/2021

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa están cubiertos por la Ley de Compensación Para Los Trabajadores de Virginia (Virginia Workers' Compensation Act). En caso de lesión por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete días después del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o más de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audiencia dentro de dos años de la fecha de la lesión por accidente o de la primera comunicación del diagnóstico de enfermedad ocupacional, sino llega a un acuerdo con el empleador en relación al pago de compensación bajo la Ley.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTA: El reporte de accidente del empleador no es la presentación del reclamo del empleado. El pago voluntario de sueldos o compensación durante la incapacidad o de los gastos médicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos años del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comisión a través de su representante o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc. Preguntas pueden ser contestadas llamando a la Comisión. Un folleto explicando la Ley de Compensación Para Los Trabajadores está disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St., Richmond, Virginia 23219

1-877-664-2566

vwc.state.va.us

Cada empleador dentro de la operación de la Ley de Compensación Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

Fecha efectiva: 2/2021