COMPLETE INFORMATION AND GIVE TO THE PANEL PROVIDER

Workers' Compensation Claimant Information

Employee Name: **SSN:**

Address: **DOB:**

City: **State:** **Zip:**

Phone: **Occupation:**
Injury: **Date of Injury:**

At California University of Pennsylvania, the Office of Environmental Health and Safety is responsible for ALL Workers' Compensation Claims.

Employer Contact Person: Diana Balla, Assistant Director of Human Resources

Employer Phone: 724-938-4427 **Employer Fax: 724-938-5740**

Employer E-Mail: balla@calu.edu

BILL TO:

Workers' Compensation Carrier: **Inservco Insurance Services, Inc.**
Pittsburgh Claims Office
P.O. Box 3899
Harrisburg, PA 17105
Phone: 800-222-0355

WORKERS' COMPENSATION CLAIM NUMBER:

(If blank, information is required to process a Claim.)

PANEL PROVIDER: Please remember to FAX a copy of the Claimant's Physical Therapy treatment/referral information to 724-938-5740 with the Fast Fax/Work Status Report.

PLEASE NOTE: *Prescription drugs for work-related injuries **ARE NOT** to be paid by your prescription drug plan.*

Revised 6/26/2017