Sedgwick Claims Kit

Tennessee

P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275

Dear Insured:

We would like to welcome you as a policyholder of Service American Indemnity Company. Sedgwick is your Claims Administrator and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachments.

Where do I report a claim?

- **Phone:** **855-728-5277 (855-7ATLAS7)**
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com
- **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

- **Website:** www.sedgwickproviders.com/AG

Sedgwick Claim Kit Attachments:

- A Beginners Guide to Tennessee Workers' Compensation
- Posting Notice – English & Spanish – ***Mandatory***
- Employer's First Report of Injury or Illness (Form C-20)
- Wage Statement (Form C-41)
- Choice of Physician Agreement – English & Spanish (Form C-42)
- Workers' Compensation Authorization for Release of Medical – English & Spanish (Form C-31)
- Express Scripts First Fill Temporary Pharmacy Card and participating pharmacies.

Need a loss run?

- **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- **Phone:** 866-738-9201
- **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

A BEGINNER'S GUIDE TO TENNESSEE WORKERS' COMPENSATION

Basic facts about the Tennessee Workers' Compensation System
For Dates of Injury on or after July 1, 2014

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

An employee should report a work-related injury to his/her supervisor within 30 days of the date of the injury or within 30 days of when a doctor first tells the employee that his/her injury is work-related so that the proper forms and paperwork can be completed.

Reporting your injury as soon as possible will speed up the handling of your claim.

All required forms should be completed by the employee's supervisor. Required forms are located on the Department of Labor and Workforce Development's website located at: http://www.tn.gov/labor-wfd/mainforms.html

If the injury requires emergency treatment, the injured worker should be taken to the closest hospital emergency room.

HOW IS A DOCTOR SELECTED?

A supervisor should provide an injured employee a panel of at least three nearby doctors willing to provide workers' compensation medical treatment. The supervisor should provide the panel of doctors on an "Agreement between Employer/Employee Choice of Physician", Form C-42. The employee must select one doctor from the Form C-42 and sign the form. The doctor chosen by the employee will become the ***authorized treating physician*** and will provide medical treatment at the employer's expense. If emergency treatment is required, the supervisor should provide the panel after the injury is stabilized.

Request and keep a copy of your signed form for your records. If you do not sign the form, but accept medical treatment from a doctor on the form, it may be considered that you have chosen that doctor.

Need More Help?

The Ombudsman Program of the Tennessee Division of Workers' Compensation is available to assist employees, employers and insurance companies that do not have attorney representation with any questions they have. Information is available on the Division's website at:

www.tn.gov/labor-wfd/wcomp.html .

Assistance is also available by calling **1-800-332-COMP (2667).**

CAN AN EMPLOYEE BE FIRED FOR REPORTING A WORK INJURY?

No, it is illegal for an employer to fire an employee for reporting a work injury. If an injured employee is fired and believes it was for reporting a work injury, the employee may wish to consult an attorney.

The Workers' Compensation Division does not have authority to resolve wrongful termination claims.

HOW CAN AN INJURED WORKER PROTECT HIS/HER RIGHTS?

The right to receive workers' compensation benefits does not stay open forever. To protect his/her rights, an injured worker must file a Petition for Benefit Determination (PBD) form. The form is available on the Division's website. In most cases, the deadline to file the form is ***one year from***:

1. The date the injury occurred; or,
2. The date the last temporary disability benefits were paid or medical benefits were provided for the injury, whichever is latest.

WHAT BENEFITS ARE INJURED EMPLOYEES ENTITLED TO RECEIVE?

Employees who have suffered a ***compensable*** injury, meaning that the authorized treating physician has determined it to be work-related, may be entitled to receive the following:

Medical treatment, at no cost to the employee:
This treatment must be provided for as long as required by the authorized treating physician. Medical treatment recommended by the authorized treating physician that is denied by the insurance company's utilization review can be submitted to the Division's Utilization Review Program for additional review and consideration.

- Reimbursement for mileage to and from medical treatment may be requested if travel exceeds 15 miles.

If the authorized treating physician restricts an injured employee's ability to work, such as limiting the number of hours worked or the type of work performed, it is very important that the physician's instructions and restrictions are followed at all times. Failure to report for light duty offered by your employer may terminate your temporary disability benefits.

Temporary Disability Benefits
Disability begins when the authorized treating physician takes an employee off work. Temporary disability benefits replace lost wages and are due beginning on the eighth day of the disability. If the disability lasts fourteen (14) days, benefits will be paid back to the first day of disability.

Temporary disability benefits are usually two-thirds (⅔) of the injured worker's average weekly wages earned during the 52 weeks prior to the injury. If you are able to work, but your average weekly earnings are reduced because of work restrictions, you may be entitled to partial disability benefits.

You should stay in contact with your employer. Temporary disability benefits are usually paid by the employer or its insurance company. The Division of Workers' Compensation does not pay these benefits.

Remember...

You can call the Ombudsman Program of the Tennessee Division of Workers' Compensation at **1-800-332-2667.** A Workers Compensation Specialist will answer your questions or direct you to someone that can.

FREQUENTLY ASKED QUESTIONS

Does an injured employee have to pay for medical treatment for a compensable injury?
No. Injured employees are not responsible for the costs of medical treatment provided by the authorized physician for a compensable claim.

What options does an employee have if they disagree with the authorized treating physician's findings or recommended medical treatment?
The employer or insurance company is usually not required by law to offer a second opinion, but you can always ask for it anyway. The employee may, however, obtain a second opinion or additional medical treatment with any doctor at his/her own expense.

What if I'm not receiving the benefits I deserve?
You can call the Workers' Compensation Division at **1-800-332-2667**. A Workers' Compensation Ombudsman will help you with your need for assistance.

Submitting a completed Petition for Benefit Determination available at: http://www.tn.gov/labor-wfd/forms/Petition%20for%20Benefit%20Determination%207.9.14.pdf will speed up the process.

Will an employee need to use his/her sick or vacation time while off work due to a compensable injury?
It depends. An employee taken off work by the authorized treating physician for less than 14 days is not entitled to temporary disability benefits for the first seven (7) days of work missed. Injured employees should review their company's policies about this unpaid time. If the authorized treating physician requires the injured employee to miss more than 14 days; however, benefits are due from the first day of disability.

Is an injured employee paid for the time spent attending doctor's appointments during work hours?
Not unless you're company has a policy to pay for this time.

Which employers must provide workers' compensation coverage for their employees?
All employers with five or more full- or part-time employees must carry workers' compensation insurance. In the construction or mining industry however, employers must provide coverage even if there is only one employee. Construction employers may exempt themselves from the workers' compensation coverage requirements by applying for an exemption; but, ***all employees*** in construction must be covered.

Information about the Workers' Compensation Exemption Registry is available at: **http://tnbear.tn.gov/WC/Default.aspx** or by calling the Tennessee Secretary of State's office at 615-741-2286.

TENNESSEE WORKERS' COMPENSATION INSURANCE

Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees.
All employers engaged in the mining and production of coal with one (1) or more employees.
All workers in the construction industry unless they are specifically exempted.

To confirm if an employer is subject to the workers' compensation law and if so to obtain the name of the workers' compensation insurance company contact:

_____
Name of employer representative authorized to provide information on workers' compensation

_____
Telephone number of employer representative to provide information on workers' compensation

_____
Address of employer representative to provide information on workers' compensation

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required.

and 2. Select a treating physician from a panel provided by the employer.

To report an injury contact:

_____
Name of employer representative to notify in event of a work related injury

_____
Telephone number of employer representative to notify in event of a work related injury

_____
Address of employer representative to notify in event of a work related injury

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Dept. of Labor and Workforce Development, Workers' Compensation Division.

and 2. Offer a panel of physicians.

The employer shall designate a group of three (3) or more physicians or surgeons not associated together in practice from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the panel shall be expanded to four (4), one of whom must be a doctor of chiropractic. If a doctor of chiropractic is chosen, chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The provisions for chiropractic care shall not apply to workers' compensation self insurer pools established pursuant to Section 50-6-405(a)(1). If the injury requires the treatment of physician or surgeon who practices orthopedic or neuroscience medicine then the employer may appoint a panel of physicians or surgeons practicing orthopedic or neuroscience medicine consisting of five (5) physicians, with no more than four (4) physicians affiliated in practice together. The employee may select a treating physician or surgeon from the employer panel.

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, has staff available to help both employees and employers. For more information contact:

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 OR TOLL FREE 1-800-332-2667 OR 1-800-332-2257 (TDD)
www.tn.gov/labor-wfd/wcomp.html

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

Todo empleador que tenga cinco (5) o más de cinco empleados de horario completo o de medio horario.

Todo empleador que se dedique a la explotación de minas y la producción de carbón que tenga un (1) empleado o más de un empleado.

Todos los trabajadores de la industria de la construcción a menos que específicamente están exentos.

Para comprobar si un empleador está sujeto a la ley de accidentes de trabajo y si ese fuera el caso, para obtener el nombre de la compañía de seguro de accidentes de trabajo a contactar:

_____

Nombre del representante del empleador

_____

Número de teléfono del representante del empleador

_____

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER UN EMPLEADO SI SE LESIONA EN EL TRABAJO?

1. Notificar al empleador de la lesión inmediatamente. Es obligatorio notificar al empleador.

y 2. Escoger a un médico que le atienda de la lista que le dé el empleador.

Para notificar una lesión póngase en contacto con:

_____

Nombre del representante del empleador

_____

Número de teléfono del representante del empleador

_____

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER EL EMPLEADOR CUANDO SE LE NOTIFICA DE UNA LESIÓN?

1. Llenar inmediatamente el formulario Primera Notificación de Accidente de Trabajo y enviarlo a la compañía de seguro de accidentes de trabajo o al administrador del seguro contra tercera persona para que lo registre en el Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo.

y 2. Ofrecer una lista de médicos.

El empleador deberá nombrar un grupo de tres (3) médicos o cirujanos o más que no estén afiliados a la misma oficina y de los cuales el empleado lesionado tendrá el privilegio de escoger ya sea el médico que le va a atender o el cirujano que le va a operar. Si la lesión es una lesión de la espalda, la lista aumentará a cuatro (4), entre los cuales habrá un médico quiropráctico. Si ud escoje un médico quiropráctico, las visitas pueden ser autorizadas hasta doce (12) vezes por la lesión de espalda. Si ud require más de doce (12) visitas al mismo médico quiropráctico tendra que tener autorización de su justador de seguransa or empleador. Las provisiones para el cuidado del quiropráctico no se aplicarán grupos de autoasegurador establecidas conforme a la Sección 50-6-405 (a) (1). Si es una lesión que requiere que le atienda un médico o cirujano que ejerce la medicina ortopédica o de neurociencias, entonces el empleador deberá nombrar un grupo de cinco (5) médicos o cirujanos que ejercen la medicina ortopédica o de neurociencias de entre los cuales sólo cuatro (4) pueden estar afiliados a la misma oficina. El empleado puede escoger un médico o cirujano de la lista del empleador para que le atienda.

El Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo tiene trabajadores disponibles para ayudar tanto al empleado como al empleador. Si necesita más información, favor de ponerse en contacto con:

DEPARTAMENTO DE TRABAJO Y DESARROLLO LABORAL DE TENNESSEE
DIVISIÓN DE ACCIDENTES DE TRABAJO
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 O LLAME GRATIS AL 1-800-332-2667 O AL 1-800-332-2257 (TDD)
www.tn.gov/labor-wfd/wcomp.html

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CITY | STATE | ZIP

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

EMPLOYER

EMPLOYER NAME | EMPLOYER FEIN | SIC CODE | PHONE NUMBER

EMPLOYER ADDRESS LINE 1 AND LINE 2 | NATURE OF BUSINESS

CITY | STATE | ZIP | INSURED REPORT # | EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM
☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ___ DAUGHTER
- ___ SON
- ___ SISTER
- ___ BROTHER
- ___ HANDICAPPED CHILD

TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)
CITY STATE ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED | PREPARER'S NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #:_____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	WEEK ENDING	GROSS WAGES
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
				TOTAL PAID	$ 64,655,456,654.00

Date: _____ Name of Preparer and Title _____

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE**: Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-31

MEDICAL WAIVER AND CONSENT

This form is not required for injuries occurring on or after July 1, 2014

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I,_____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)

_____ to furnish to my employer or my employer's
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my

work-related injury of _____for which I am claiming compensation. I further authorize the release of
(Date of Injury)

the same information to me or my attorney. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

_____

Patient Signature Date Date of Birth

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: GJC6200

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ ____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

sedgwick

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School
Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P & C Food
Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology
Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

EXPRESS SCRIPTS®