First Fill Form

Client Name: Packard Claims Administration

S1 Medical has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. This form will serve to fill the initial injury-related prescriptions for up to 7 days. If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail, to be used to fill potential future prescriptions.

Injured Worker Name:
Injured Worker DOB:
Injured Worker Employer: Packard Claims
Injured Worker Address:
City:
SS#:
Injured Worker Phone:
Date of Injury:
State:
Zip:

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work-related injury/illness**
- **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

3. Instructions for the **PHARMACY**:

Please submit workers' compensation claims to **S1 Medical** using the following information:

BIN	PCN	Group Id	Member Id
610237	123119	PACKARD	Injured Worker SS#

Prescription(s) will fill for up to **7 Days.** If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at **(844) 700-5382**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (844) 700-5382

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY

OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name Southeast Personnel Leasing, Inc. & Subsid	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
5. Physical Address 1 2739 US HWY 19 N	10. Mailing Address 1
6. Physical Address 2	11. Mailing Address 2
7. City Holiday 8. State fl 9. Zip 34691	12. City 13. State 14. Zip

15. Federal ID Number 59-3565930	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name Lion Insurance Company	21. Filing Office Name
19. Insurer Federal ID Number 59-3565930	22. Mailing Address 1 2739 US HWY 19 N
	23. Mailing Address 2 or Telephone Number
	24. City HOLIDAY 25. State FL 26. Zip 34691
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐	27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐
34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐ 41. Date of Birth 42.Nbr of Dependents
43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment First Aid By Employer ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐	No Medical Treatment ☐ Minor Clinic / Hospital ☐ Hospitalized Overnight ☐ Outpatient Treatment ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number