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

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	Date of Accident (Month/Day/Year)	Time of Accident	Social Security Number

HOME ADDRESS
Street/Apt #: _____
City: _____ State: _____ Zip: _____
TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED

DATE OF BIRTH	SEX
.	☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____
D. B. A.: _____
Street: _____
City: _____ State: _____ Zip: _____
TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

NATURE OF BUSINESS

DATE FIRST REPORTED (Month/Day/Year)

POLICY/MEMBER NUMBER
WC 71949

DATE EMPLOYED

PAID FOR DATE OF INJURY
☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street: _____
City: _____ State: . Zip: _____
LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES ☐

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

PLACE OF ACCIDENT (Street, City, State, Zip)
Street: _____
City: _____ State: _____ Zip: _____
COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

AGREE WITH DESCRIPTION OF ACCIDENT?
☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ DAY ☐ MO
Number of hours per day _____
Number of hours per week _____
Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits a felony of the third degree. Section 440.185(4), F.S. I have reviewed, understand and acknowledge the above statement.

_____ _____
EMPLOYEE SIGNATURE (If available to sign) DATE

_____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1. Denied Case - DWC-12, Notice of Denial Attached ☐ 2. Medical Only which became Lost Time Case (Complete all information in #3)

☐ 3. Lost Time Case - 1st day of disability Salary continued in lieu of comp? ☐ YES Salary End Date

Date First Payment Mailed AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH. ☐ SETTLEMENT ONLY

Employee's 8TH Day of Disability Claims-Handling Entity's Knowledge of 8TH Day of Disability

☐ 4. Number of Days Disabled as of Date First Payment Mailed:_____ Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

NSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

PACKARD CLAIMS ADMINISTRATION
P.O. Box 1549
Tarpon Springs, Fl. 34668
(866) 605-8601

Is employer self-insured? ☐ YES ☐ NO

Form DFS-F2-DWC-1 (mm/dd/2004)