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

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? ☐ Yes ☐ No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? ☐ Yes ☐ No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? ☐ Yes ☐ No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? ☐ Yes ☐ No		Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12