



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

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE			
				JURISDICTION		JURISDICTION CLAIM NUMBER					
				INSURED REPORT NUMBER							
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #			
CARRIER/CLAIMS ADMINISTRATOR											
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
				TO							
				CHECK IF APPROPRIATE							
				<input type="checkbox"/> SELF INSURANCE							
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN					
AGENT NAME & CODE NUMBER											
EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
				<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS			
				# OF DEPENDENTS				NCCI CLASS CODE			
PHONE											
RATE PER:		<input type="checkbox"/> DAY <input type="checkbox"/> WEEK		<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:		DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		<input type="checkbox"/> AM <input type="checkbox"/> PM		LAST WORK DATE	
						() CANNOT BE DETERMINED				DATE EMPLOYER NOTIFIED	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO											
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				<input type="checkbox"/> YES <input type="checkbox"/> NO			
				WERE THEY USED?				<input type="checkbox"/> YES <input type="checkbox"/> NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
								0 NO MEDICAL TREATMENT			
								1 MINOR: BY EMPLOYER			
								2 MINOR CLINIC/HOSP			
								3 EMERGENCY CARE			
								4 HOSPITALIZED > 24 HOURS			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED							
OTHER											
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.