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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY | PHONE NUMBER

EMPLOYEE:
MALE ☐ MARRIED ☐
FEMALE ☐ SINGLE ☐

NUMBER OF DEPENDENTS | DATE OF BIRTH

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN) | EMPLOYMENT STATUS

FT = Full-time
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIC CODE | EMPLOYER FEIN | PHONE NUMBER

COUNTY | NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES ☐
NO ☐

TIME EMPLOYEE BEGAN WORK AM ☐ PM ☐

TIME OF OCCURRENCE AM ☐ PM ☐

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LAST DAY WORKED | DATE DISABILITY BEGAN

DATE EMPLOYER NOTIFIED | DATE RETURNED TO WORK | DATE OF HIRE

CONTACT FIRST NAME | CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

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(OVER)

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

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

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING 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 DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME:

STREET

CITY STATE ZIP

HOSPITAL NAME:

STREET

CITY STATE ZIP

POLICY PERIOD FROM:

POLICY PERIOD TO:

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

DATE PREPARED

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Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.