OPTUM®

First Fill Information
Packard Claims

Dear Injured Worker,

Optum® has been selected by **Packard Claims** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Optum has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at **cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: **1-800-419-7191.**

Estimado Trabajador(a) Lesionado(a),

Optum ha sido seleccionado por **Packard Claims** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Optum cuenta con una extensa red de farmacias al por menor. De la red de farmacias Optum incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en **cypresscare.com** y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: **1-800-419-7191.**

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 **Group Number: PACKARDCLAIMS**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:	SouthEast Personnel Leasing	
Date of Injury:		

Pharmacy Help Desk: **1-800-419-7191**

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 14-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at **1-800-419-7191.**

Issuance of this letter does not constitute acceptance of your claim.

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
	22. Mailing Address 1 2739 US HWY 19 N
19. Insurer Federal ID Number 59-3565930	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