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.

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)