



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:

Employer Name:

SouthEast Personnel Leasing

Injured worker's first & last name

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.

Optum Workers' Compensation Services of Georgia | P.O. Box 2829 | Suwanee, GA 30024 | F 1-678-730-1008

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name SOUTHEAST PERSONNEL LEASING, INC.	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)	
Address 2739 US HWY 19 N		Phone Number 800-966-5562	Employer FEIN 59-3298197	
City HOLIDAY	State FL	Zip Code 34691	Employer E-mail	
INSURER / SELF-INSURER	Name LION INSURANCE COMPANY	Insurer/Self-Insurer FEIN 59-3565930	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name PACKARD CLAIMS ADMIN.	Claims Office FEIN # 03-05-67602	Claims Office Phone 866-605-8601	Claims Office E-mail
SBWC ID# (five digit no.) 13220	Address PO BOX 1549	City TARPON SPRINGS	State FL	Zip Code 34691
EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month
Insurer Type Code <input type="checkbox"/> - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> Group Fund		List Normally Scheduled Days Off		
INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death
Report Prepared By (Print or Type)			Telephone Number	Date of Report

B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____	Weekly benefit: \$ _____	Date of disability:
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____			
BENEFITS ARE PAYABLE FROM _____ FOR:			
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.			
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.			

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY No disability paid or controverted

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone and Ext.	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.ga.gov>
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwc.georgia.gov>