



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

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name		Employee's SSN	Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**
 By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12