

MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.




Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA _____ EMPLOYER _____

INJURED WORKER NAME _____

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER _____ DATE OF INJURY (YYMMDD) _____

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk 1-800-964-2531

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PKCLFF		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.



Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



La mayoría de farmacias y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?

¿Necesita ayuda?



1-866-599-5426

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk 1-800-964-2531

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261		002538
RxPCN	CAL		Envoy Acct. #
GROUP	PKCLFF		

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."



IMP14-1614-109-PKCLFF

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.

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 INJURYWERE 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.