

Business Insurers of Georgia

AUTHORIZATION FOR MEDICAL TREATMENT FOR WORKERS' COMPENSATION

**Use this form for injured workers in the following states:
AR, AZ, CO, CT, DC, DE, HI, IA, ID, KS, MA,
ME, MN, MT, NE, NM, NV, OK, RI, SD, UT, VT**

PROVIDER: Prescient National Insurance Services / Gallagher Bassett Services, Inc.
POLICY: Business Insurers of Georgia #WC080-000001-124

COMPANY NAME: _____

EMPLOYEE NAME: _____

DATE OF INJURY: _____

TYPE OF INJURY: _____

PERFORM A 10-PANEL DRUG SCREENING: YES / NO (CIRCLE ONE)

PERFORM A BLOOD ALCOHOL SCREENING: YES / NO (CIRCLE ONE)

Submit all charges on CMS 1500 (red form), UB04 form, or accordingly on each state's industrial commission approved form. **Please include medical notes, W-9 form, and claim number if available.** Bills must be submitted using the following method.

MAIL: Gallagher Bassett Services, Inc.
P.O. Box 2831
Clinton, IA 52733-2831

The Gallagher Bassett Services, Inc. claims under this policy are associated with myMatrixx. Because the Pharmacy Benefits Manager issues prescription cards to injured workers, **ALL PHYSICIAN DISPENSED MEDICATIONS ARE NOT AUTHORIZED/HONORED** by Gallagher Bassett Services, Inc.

SIGNATURE OF SUPERVISOR

DATE

Medical Authorization

The undersigned person(s) hereby consents to, and by the Authorization or any photocopy hereof authorizes, the release to Prescient National Insurance Services or any other agent or employee of Prescient National Insurance Services by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies to

(Name of Patient, Claimant)

Of any and all medical report, histories, findings, prognosis, diagnosis, bills, information or other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including but not limited to psychiatric treatment, or treatment for alcoholism or drug abuse, of such patient.

The undersigned person(s) understands and hereby acknowledges that the information above or certain portions thereof, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.

The Authorization shall automatically expire without express revocation one year after signature date below.

And prior to such time shall be subject to revocation with respect to all or any particular records at any time by the undersigned person(s) in writing delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

Date: _____

Claimant: _____
(Print Name)

Claimant: _____
(Signature)

Date: _____

Witness: _____
(Print Name)

Witness: _____
(Signature)

Autorización Médica

La(s) persona(s) abajo firmante(s) consiente, y por la Autorización o cualquier fotocopia del presente document, autoriza la divulgación a Prescient National Insurance Services o cualquier otro agente o empleado de Prescient National Insurance Services por parte de cualquier hospital, clínica médica, cirujano, medico, farmacéutico o cualquier otro proveedor de servicios medicos, tratamiento o suministros para

(Nombre del Paciente, Reclamante)

De todos y cada uno de los informes médicos, historiales, hallazgos, pronóstico, diagnóstico, facturas, información u otros documentos relacionados con cualquier tratamiento médico, hospitalización, medicamentos recetados u otros servicios o suministros médicos, incluidos, entre otros, tratamientos psiquiátricos o tratamientos para el alcoholismo o abuso de drogas, de tal paciente.

La(s) persona(s) abajo firmante(s) entiende y por la presente reconoce que la información anterior o ciertas partes de la misma pueden estar protegidas contra la divulgación sin esta Autorización firmada por las leyes federales y estatales de privacidad y confidencialidad.

La Autorización caducará automáticamente sin revocación expresa un año después de la fecha de firma a continuación.

Y antes de ese tiempo estará sujeto a revocación con respecto a todos o cualquier registro en particular en cualquier momento por la(s) persona(s) abajo firmante(s) que se entreguen al titular de dichos registros, excepto en la medida en que ya se haya tomado acción en dependencia de esta Autorización.

Fecha: _____

Demandante: _____
(Imprimir Nombre)

Demandante: _____
(Firma)

Fecha: _____

Testigo: _____
(Imprimir Nombre)

Testigo: _____
(Firma)

Occupational Injury Temporary Prescription ID Card



To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control WC
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury

myMatrixx, an Express Scripts Company

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: NZEA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies

A & P	Drug Emporium	Longs Drug Store	Sav-On
Acme Pharmacy	Drug Fair	Major Value	Save Mart
Albertson's	Drug Town	Marsh Drugs	Schnucks
Albertson's/Acme	Drug World	Medic Discount	Scolari's
Albertson's/Osco	Eckerd	Medicap	Sedano
Albertson's/Sav-On	Econofoods	Medistat	Shaw's
Amerisource Bergen	EPIC Pharmacy	Meijer	Shop 'N Save
Anchor Pharmacies	Network	Minyard	Shopko
Arrow	FamilyMeds	NCS HealthCare	ShopRite
Aurora	Farm Fresh	Neighborcare	Snyder
Bartell Drugs	Farmer Jack	Network	Stop & Shop
Bigg's	Food City	Pharmaceuticals	Sun Mart
Bi-Lo	Food Lion	Northeast Pharmacy	Super Fresh
Bi-Mart	Fred's	Services	Super Rx
BJ's Wholesale Club	Gemmel	Osco	Target
Brooks	Giant	P & C Food Markets	Texas Oncology Srvs
Brookshire Brothers	Giant Eagle	Pamida	The Pharm
Brookshire Grocery	Giant Foods	Park Nicollet	Thrifty White
Bruno	Hannaford	Pathmark	Times
Carrs	Harris Teeter	Pavilions	Tom Thumb
Cash Wise	H-E-B	Price Chopper	Tops
Coborn's	Hi-School Pharmacy	Publix	Ukrop's
Costco	Hy-Vee	Quality Markets	United Drugs
Cub	Jewel/Osco	Raley's	United Supermarkets
CVS	Kash n Karry	Randalls	Vons
D&W	Keltsch	Rite Aid	Waldbaums
Dahl's	Kerr	Rosauers	Walgreens
Dierbergs	Kmart	Rx Express	Wal-Mart
Discount Drugmart	Knight Drugs	RXD	Wegmans
Doc's Drugs	LeaderNet (PSAO)	Safeway	Weis
Dominicks		Sam's Club	Winn Dixie