

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed up the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

»» To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 15-day supply or a cost of \$300. (Note: the limit on post exposure prophylaxis is \$3,000). This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

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



ID#: (Claimant will provide verbally)

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 #: NX8A

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

	M	
First		Last
Street Address or PO Box		
City	State	ZIP