Worker's Compensation Packet

You will need to contact the Human Resources Dept. to **meet with someone immediately**, or on the next business day. It is of vital importance that you do not delay. Please call (717) 854-7742 and ask for the Human Resources Dept. to connect with someone.

Please review and complete this packet in its entirety.

Thank you.

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider, however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for that first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another and that treatment will be paid for by your employer.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more that five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Panel and non-panel health care providers must accept payments as calculated under the Pennsylvania Workers' Compensation Act. You are not responsible for any payment in excess of the charges calculated under the Act, unless your treatments are unrelated to the compensable injury or are otherwise beyond the scope of your employer's workers' compensation insurance coverage.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

All Health care providers must provide regular reports to your employer/insurance carrier concerning your treatment and your ability to resume employment.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKER'S COMPENSATION ACT AS SET FORTH HEREIN.

DATE: _____ _____
Employee

EMPLOYEE RE-NOTIFICATION

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Worker's Compensation Act. I have received a copy of this Worker's Compensation employee notification form.

DATE: _____ _____
Employee

Workers' Compensation Information

The following information is being provided to you in compliance with 34 Pa.Code § 121.3b.

1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

3) You should report immediately any injury or work-related illness to your employer.

4) Your benefits could be delayed or denied if you do not notify your employer immediately.

5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Employee's Signature: _____

Date: _____

NOTICE TO ALL EMPLOYEES

IN THE EVENT OF A WORK INJURY, TELL YOUR SUPERVISOR!

If you are injured while at work, your employer has arranged for payment of your medical care with:

The Shadowfax Corporation / PCPA / INSERVCO

386 Pattison Street, York, PA 17403 (717) 854-7742

It is your responsibility to immediately report the injury to your supervisor.

IN CASE OF A WORK-RELATED INJURY OR DISEASE:

In accordance with the PA Worker's Compensation Act, you must choose a medical provider from the list below.
If you suffer a work-related injury or disease, your employer or its insurance company will pay for reasonable surgical and medical services, medication, supplies, orthopedic appliances and prostheses, including training in their use. In order to ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the licensed physicians or practitioners of the healing arts listed below:

UPMC Express Care locations:

Greenbriar Medical Center
520 Greenbriar Rd., York, PA 17404
(717) 764-9729

2030 Thistle Hill Dr.., Spring Grove, PA.
Spring Grove, PA.
(717) 225-9869

5615 York Rd, New Oxford, PA.
(717) 624-1337

1404 Baltimore St. Hanover, PA (717) 637-0470

Concentra Medical Center
970 Loucks Rd., York PA 17404
(717) 764-1008

Patient First
2960 E. Market St
York, PA. 17402 717-751-2483

Med Express
400 Loucks Rd
York, PA. 17404 717-845-2273

General Surgeon
Wellspan- Apple Hill Surgical Center
25 Monument Rd., Suite 220,
York PA 17403
(717) 41-0733 or (717) 843-0637

Physical Therapy
CPRS
3601 East Market St. York, PA. 17402
(717) 755-2120

Orthopaedic & Spine Specialists
1855 Powder Mill Rd., York, PA 17402
(717) 848-4800

Orthopaedic
Orthopaedic & Spine Specialists
1855Powder Mill Rd. York,PA 17402
(717) 848-4800
Urgent care (717) 747-8315

Orthopaedic & Spine Specialists
1750 5th Ave., Suite 201, York PA 17403
(717) 848-2297

Orthopaedic & Spine Specialist Hospital
1861Powder Mill Rd., York PA 17403
(717) 718-2000

Imaging (x-ray/CAT scan/MRI)
One Call Medical
800-872-2875

Neurology
Dr. Anthony May
228 St. Charles Way, York PA 17402
(717) 851-5503

Ophthalmology/Ophthalmic Surgery
Ophthalmology Associates of York
1945 Queenswood Dr., York PA 17403
(717) 846-6900

Chiropractic
Leader Heights Healthcare
2595 S. George St., York, Pa. 17403
866-446-2848

Eye Injuries
Jacques Surer, MD
1750 5th Ave., Suite 301, York PA 17403
(717) 843-7829

Internal Medicine
Internal Med. Consultants of York
1777 Fifth Ave., York, PA. 17403
(717) 843-8051

- ***That the employee has the duty*** to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- ***That the employee has the right*** to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as the treatment is obtained from a designated provider during the 90-day period.
- ***That the employee has the right***, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
- ***That the employee has the right*** to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
- ***That the employee has the right*** to seek emergency medical treatment from any provider, but that subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- ***That the employee has the right*** to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
- ***That the employee has the right*** to seek treatment from any health care provider after the 90-day period has ended, and the treatment shall be paid for by the employer, if it is reasonable and necessary.
- ***That the employee has the duty*** to notify the employer of treatment by a non-designated provider within five (5) days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C.

Workers' Compensation Claim
(LIBC 500)

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR EMPLOYER'S WORKERS' COMPENSATION INSURANCE COMPANY, THIRD-PARTY ADMINISTRATOR (TPA), OR PERSON HANDLING WORKERS' COMPENSATION CLAIMS FOR YOUR COMPANY, IS CONTAINED BELOW.

EMPLOYER NAME: The Shadowfax Corporation DATE POSTED: 10/02/09

IF INSURED:
(Complete all applicable spaces)

NAME OF INSURANCE COMPANY:

ADDRESS:

TELEPHONE NUMBER:

INSURER'S BUREAU CODE: ____ ____ ____ ____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

NAME OF TPA (Claims administrator):

ADDRESS:

TELEPHONE NUMBER:

IF SELF-INSURED:
(Complete all applicable spaces)

NAME OF PERSON HANDLING CLAIMS AT THE SELF-INSURED:

ADDRESS:

TELEPHONE NUMBER:

SELF-INSURED BUREAU CODE: 5 5 0 7

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

NAME OF TPA (Claims administrator):

Inservco Insurance Services

ADDRESS: PO Box 3899

Harrisburg PA 17105

TELEPHONE NUMBER: 800-356-0438

LIBC-500 REV 5-00

Shadowfax

Slip, Trip, Fall Injury Review Form

Employee Name:		
Title:	**Department:**	**Date of Accident:**
Description of Accident:		
Location of Accident:		
Proper Footwear Worn At Time Accident		☐ Yes ☐ No
Adequate Lighting Conditions		☐ Yes ☐ No
Weather Conditions		☐ Rain ☐ Snow ☐ Ice ☐ Wet Leaves ☐ Sun Glare

What Issues Caused the Accident (check all that apply:

- ☐ Cracks in Walking Surface
- ☐ Uneven Walking Surface
- ☐ Pothole in Parking Lot
- ☐ Liquid Spill
- ☐ Loose Handrail
- ☐ Defective Ladder
- ☐ Not Utilizing Ladder
- ☐ Tripped Over Object
- ☐ Curled Floor Mat
  - ☐ Rippled or Torn Rug
- ☐ Uneven Walking Surface
  - ☐ Cords or Wires
- ☐ Non-Slip Stair Treads Worn or Buckled
- ☐ Uneven Walking Surface
- ☐ Snow or Ice
- ☐ Other (describe below):

Describe Other:

Tips To Avoid Future Slip, Trip, or Fall Accidents:

- Wear appropriate footwear in inclement weather and never wear flip-flops.
- Always be aware of your surroundings. Look where you're going.
- Use three-points of contact when exiting a vehicle in snowy or icy conditions.
- Wipe up spills immediately.
- Never substitute other objects for a ladder.
- Never carry large objects that obstruct your view. Ask for assistance or for someone to guide you.
- Always hold the handrail when ascending or descending stairs.

I acknowledge and understand that the intent of this form is to assist me in recognizing hazards that may lead to slip, trip, or fall injuries, as well as ways to prevent them.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Shadowfax Corporation PCPA 0040794

First Report of Injury

Employee Information

TO BE COMPLETED BY EMPLOYEE

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Injury (mm/dd/yyyy)_____

Employee Name (proper name only; no middle initial; no punctuation; include Jr, Sr or other title after last name)

First Name _____ Last Name _____

Employee Address

Street _____

City/State/Zip _____ County _____

Phone (_____) _____ - _____

Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married

Number of Dependents _____ Date of Birth (mm/dd/yyyy) _____

Job Title _____ Employment Status (check one) ❑ Full-time ❑ Part-time

Claim Information

Full Pay for Day of Injury? ❑ Yes ❑ No

Time Employee Began Work _____ ❑ AM ❑ PM

Time of Occurrence _____ ❑ AM ❑ PM

Last Day Worked (mm/dd/yyyy) _____

Date Disability Began (mm/dd/yyyy) _____

Date Employer Notified (mm/dd/yyyy) _____

Has Employee Returned To Work? ❑ Yes ❑ No

Date Returned To Work (mm/dd/yyyy) _____

Date of Hire (mm/dd/yyyy) _____

Type of Injury or Illness Code (see attached list) _____

Part of Body Affected Code (see attached list)_____

Cause of Injury Code (see attached list) _____

Codes are on a following page →

Did Injury or Illness Occur on Employer's Premises? ❑ Yes ❑ No

If Out of State, Specify State of Injury _____

Were Safeguards or Safety Equipment Provided? ❑ Yes ❑ No ❑ Not Applicable

Were Safeguards or Safety Equipment Used? ❑ Yes ❑ No ❑ Not Applicable

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 _____

_____

_____

_____

_____

_____

_____

Date of Death (if fatal only; mm/dd/yyyy) _____

Initial Treatment (check one)

☐ No Medical treatment ☐ Minor by employee ☐ Clinic/Hospital

☐ Panel Physician ☐ Emergency Care ☐ Hospitalized more than 24 hours

Panel Physician/Health Care Provider

First Name _____ Last Name _____

Street _____

City/State/Zip _____

Hospital Name _____

Street _____

City/State/Zip _____

Other

Witness Name(s)

#1. First Name _____ Last Name _____

Phone (_____) _____ - _____

#2. First Name _____ Last Name _____

Phone (_____) _____ - _____

Person Completing This Form (if other than the employee, state reason employee did not complete)

_____ _____

Signature **Date**

_____ _____

Printed Name **Reason (if applicable)**

Comments (These comments will be entered into claim file notes)

_____

_____

_____

FOR HR OFFICE USE ONLY:

Claim #	Date submitted to HR	Date submitted to Inservco	Date claim closed

Injury Type Codes

01	No Physical Injury	34	Hernia	60	Dust Disease, NOC	76	VDT-Related Disease
02	Amputation	36	Infection	61	Asbestosis	77	Mental Stress
03	Angina Pectoris	37	Inflammation	62	Black Lung	78	Carpel Tunnel Syndrm
04	Burn	40	Laceration	63	Byssinosis	79	Hepatitis C
07	Concussion	41	Myocardial Infarctn	64	Silicosis	80	Other Cumulative Inj
08	Hearing Loss	42	Poisoning-General	65	Rsprtry Dsrdrs	90	Mltpl Physical Inj
10	Contusion	43	Puncture	66	Poisn-Chem(non-mtls)	91	Mltpl Inj Phys or Psych
13	Crushing	46	Rupture	67	Poisoning-Metal		
16	Dislocation	47	Severance	68	Dermatitis		
19	Electric Shock	49	Sprain	69	Mental Disorder		
22	Enucleation/Removal	52	Strain	70	Radiation		
25	Foreign Body	53	Syncope/Fainting	71	Othr Occ Dse Inj NOC		
28	Fracture	54	Asphyxiation	72	Loss of Hearing		
30	Freezing	55	Vascular	73	Contagious Disease		
31	Hearing Loss/Imprmnt	58	Vision Loss	74	Cancer		
32	Heat Prostration	59	All Othr Spc Inj NOC	75	AIDS		

Body Part Codes

10	Multiple Head Injury	24	Larynx	41	Upr Bck Area(Thrcic)	55	Ankle
11	Skull	25	Neck - Soft Tissue	42	Lw Bck Area(Lbr&Lbo)	56	Foot
12	Brain	26	Trachea	43	Back/Disc	57	Toe(s)
13	Ear(s)	30	Mltple Upr Extrmtes	44	Chest(Ribs&Sft Tsue)	58	Great Toe
14	Eye(s)	31	Upr Arm(Clvcl-Scpla)	45	Sacrum and Coccyx	60	Lungs
15	Nose	32	Elbow	46	Pelvis	61	Abdomen incl Groin
16	Teeth	33	Lower Arm	47	Back - Spinal Cord	62	Buttocks
17	Mouth	34	Wrist	48	Internal Organs	63	Lumbar/Sacral Vertbr
18	Head - Soft Tissue	35	Hand	49	Heart	64	Artificial Appliance
19	Facial Bones	36	Finger(s)	50	Mltple Lwr Extrmtes	65	Insf Info 2 Prop Id
20	Neck - Multiple Inj	37	Thumb	51	Hip	66	No Physical Injury
21	Vertebrae	38	Shoulder	52	Upper Leg	90	Multiple Body Parts
22	Neck - Disc	39	Wrist(s) and Hand(s)	53	Knee	91	Bdy Sys/Mtpl Bdy Sys
23	Neck - Spinal Cord	40	Multiple Trunk	54	Lower Leg	99	Whole Body

Cause Codes

Burn, Heat Or Cold Expos.		15	Cut/Inj By-Brkn Glas	57*	Str/Inj By-Push/Pull	80*	Strk-Obj Hndl by Others
2*	Burn-Cntct w/ Object	17	Cut-Obj Liftd/Handld	58*	Strain/Inj By-Reach	86	Inj By-Explosion or Flare
3*	Burn-Temp Extremes	**Fall or Slip**		60*	Strain/Inj By-Misc	**Rubbed or Abraided**	
1*	Burn-Acid Chem	25*	Fall/Slip-Diff Level	54	Strain/Inj By-Jump	94*	Rubbed/Abraided by Repetive Motion
84*	Electrical Current	29*	Fall/Slip-Same Level	59	Str/Inj By-Tool/Mach	95*	Rubbed/Abraided by Misc
4	Burn-Fire or Flame	33	Fall/Slip-On Stairs	61	Strain/Inj By-Throw	**Miscellaneous**	
5	Burn-Steam/Hot Fluid	26	Fall/Slip-Ladder	97	Strain-Repitv Motion		
11	Burn-Cold Obj/ Subst	28	Fal/Slp-Into Opening	53	Strain/Inj By-Twist	90*	Other than Phys Cause
7	Burn-Welding	32	Fall/Slip-Ice/Snow	**Strike Against or Step On**		52*	Strain/Inj By Continuous Noise
8	Burn-Radiation	27	Fall/Slip-Liquid	70*	Step On/Strike-Misc	85*	Inj By-Animal/Insect
6	Burn-Dst/Gas/Fms/Vpr	30	Slip-Did Not Fall	65	Step/Strik-Machine	89*	Misc-Person in Act of Crime
14	Brn-Abnml Air Presur	31	Fall/Slip-Misc	66	Step/Strk-Obj Handld	82*	Misc-Absorb/Ingest/Inhalation
9	Burn-Miscellaneous	**Motor Vehicle**		67	Step/Strik-Scraping	87*	Forgn Matter in Eye
		50*	Motr Veh-Misc	68	Step/Strk-Statnry Ob	98	Misc-Cumulative
Caught In or Beteween		46	Motr Veh-Hit Fxd Obj	69	Step/Strik-Sharp Obj	99	Misc-Other**
13*	Caught In/Betwn-Misc	45	Motr Veh-Veh Colison	**Struck By**			
10	Caught In-Machinery	48	Motr Veh-Veh Upset	74*	Struck-Cowrker/Other		
12	Caught In-Obj Handld	41	Motr Veh-Train	75*	Struck-Fall/Fly Obj		
20	Caught In-Collapse	47	Motr Veh-Airplane	76*	Struck-Tool/Machine		
Cut, Puncture or Scrape		40	Motr Veh-Water Veh	81*	Sruck/Inj By-Misc		
16*	Cut/Inj By-Hand Tool	**Strain or Injury By**		77	Struck-Motor Veh		
18*	Cut/Inj By-Powr Tool	55*	Strn/Inj-Hold/Carry	78	Struk-Machine In Use		
19*	Cut/Inj By-Misc	56*	Strain/Inj By-Lift	79	Struck-Obj Handled		

EMPLOYEE INCIDENT / ACCIDENT REPORT

Please print all information legibly.

Date of this report: _____ Time of this report: _____ AM/PM

Name: _____ Position: _____

Person filling out this report: _____

Date of injury or accident: _____

Program#/Location where injury or accident occurred: _____

Name of Supervisor: _____

Length of time that you've worked in area where injury/accident occurred: _____

Date returned to work: _____

Answer all of the following completely and with detail. Print legibly.

What was the physical condition of the area when the accident occurred?

_____

_____

Describe what you were doing when the injury or accident happened:

_____

_____

Were you familiar with the job and procedures?

_____

_____

Were you authorized and qualified to conduct this job/procedure?

_____

_____

Were proper tools and/or equipment being used?

_____

_____

What type of hazard prevention training did you receive prior to the accident?

_____

_____

Were approved procedures being followed?

_____

_____

Describe any underlying causes of this injury or accident.

_____

_____

Was safety equipment provided for your use? (If yes, describe what kind.)

_____

_____

Were you using the safety equipment? (If no, explain why you were not using it.)

Was the proper supervision being provided?

Had corrective action been recommended in the past but not adopted?

Describe how the incident/injury occurred.

Body parts affected:

Supervisor recommendation:

Supervisor comments:

Supervisor review date: _____ Supervisor Signature: _____

SAFETY COMMITTEE USE ONLY Incident/Accident Report # _____

Date received: _____ Time received: _____ AM/PM

Safety Committee Chairperson's Initials: _____

Supervisor recommendation approved by committee? ____Yes ____No

Additional recommendation to be taken to prevent further reoccurrence of injuries/accident of this type:

Date recommendation implemented/completed: _____

Safety Committee review date: _____

Safety Committee Chairperson's Signature: _____

KeyScripts
BENEFITS MANAGEMENT

Toll Free 1.866.446.2848
www.keyscriptsllc.com
Fax 717.732.9467

INSTRUCTIONS FOR PRESCRIPTION BENEFIT CLAIMS

To the Card Holder:

The attached Prescription Benefit Card requires activation by telephone. Once activated, it will authorize you to obtain only those prescription medications that are directly related to your work injury. This card contains important information about your employer's prescription drug plan, and you must present it to your pharmacist when filling prescription related to your work injury.

If your employer has called to activate your card, they will either fill in the required information on the card or provide you with the information needed to complete it. If your employer has not called to activate your card, you must call to activate the card prior to taking it to the pharmacy. When you call, you will be asked to provide your name, date of birth, employer's name and telephone number, and the date of injury. Please have this information available when you call.

CALL 1.866.446.2848 TO ACTIVATE YOUR CARD, OR IF YOU NEED MEDICAL EQUIPMENT & SUPPLIES

At the time of your call, write the ID number provided to you on your Prescription Benefit Card. Upon completion of your call, your card will be immediately activated. You may then take it to your pharmacy, and your prescription(s) will be filled subject to the following conditions:

- The prescription(s) must be related to your work injury; should you attempt to use this card for any other prescriptions, it will become your responsibility to pay for them.
- There may be limitations on how much of your prescription can be filled.
- Our clinical staff may need to review certain information before filling your prescription. We will let your pharmacist know if this is the case.

Please avoid having any prescription related to your work injury filled directly by the prescribing physician's office, as most physicians do not accept prescription benefit cards similar to KeyScripts' for billing purposes. You may visit the KeyScripts network pharmacy of your choice, which includes all of the major retail pharmacies, such as CVS, Rite Aid, Target, Walgreens and Wal-Mart. You can quickly find your nearest KeyScripts network pharmacy by using the pharmacy search feature on our home page, at www.keyscriptsllc.com, or call our toll-free customer service center at 1.866.446.2848.

Here is your KeyScripts Prescription Benefit Card containing important claims and customer service information for you and your pharmacist. After activation, detach the lower portion of this letter and present it to your pharmacist when filling your prescription.

Detach Here

KeyScripts
BENEFITS MANAGEMENT

For customer service, call toll free, at 1.866.446.2848

Bin #: 009430
Plan ID: KeyScripts

Employee Name: _____

Employee ID: _____

Workers' Compensation Prescription Benefit Card

To the Employee: Present this card to your pharmacy of choice for any prescription drug related to your worker's compensation injury. This card is for identification purposes only, and your pharmacist may require additional/photo identification at time of fill. Unauthorized or fraudulent use of this card is punishable by law. We reserve the right to revoke this card at any time.

To the Pharmacy: Submit claims via the ProCare System only for the person for whom the prescription was written.

ProCare Rx
3090 Premiere Parkway, Suite 100
Duluth, GA 30097
Pharmacy Help Desk 1.800.277.1657