



Accident/Incident Vehicle Packet

Town of Collierville

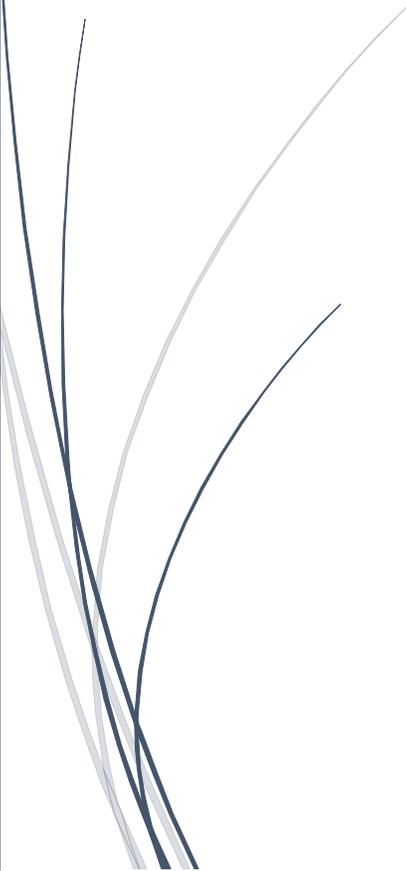


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ACCIDENT/INCIDENT REPORTING INSTRUCTIONS

If you are involved in an accident or have a liability claim, please follow these steps:

At the Scene of the Accident/Incident:

- 1) Report accident to your Supervisor immediately.
- 2) Contact Police Dispatch at 853-3207 to make an official accident report for incidents involving vehicles.
- 3) Give the "Insurance Claim Contact Information" (Page 2) to the other party involved in the accident/incident.
- 4) Complete "Accident Form" located on page 4.
- 5) Take pictures if possible.

Post Accident/Incident Requirements:

- 1) Supervisor is to email, fax, or deliver the Accident Form/Supervisor's Investigative Report (Page 4-5) containing all the information to insuranceclaims@collierville.tn.gov / 457-2258 / Town Hall within 24 hours of the accident/incident. Include the Police Report and pictures if you have them.
- 2) The Risk Management office will file the insurance claim (if required).

Out-of-Town Accident/Incident Reporting:

- 1) If accident/incident occurs outside of Collierville, you should call the local authorities.
- 2) Go through numbers 1-5 of the "At the Scene of the Accident/Incident" shown above.
- 3) The Town's Risk Management office will obtain a copy of the jurisdiction's accident report. You have the responsibility of notifying the appropriate representatives in all cases. The Risk Management office will handle the entire insurance claim process. Make no statement without the Town's representative's approval.

Per Human Resources:

- 1) A completed First Report of Injury (page 7) and Supervisors Investigative Report (page 5) should be forwarded to the H/R Department within 24 hours of the accident/incident. This should be done even if the employee did not sustain a noticeable injury. If you have any questions, please contact the H/R Department at 457-2290.

Stan Joyner,
Mayor

Tom Allen, *Alderman*
Maureen Fraser, *Alderman*
John E. Stamps, *Alderman*
Billy Patton, *Alderman*
John Worley, *Alderman*



James H. Lewellen
Town Administrator

Lynn Carmack
Town Clerk

Town of Collierville

(Give to other party involved)

INSURANCE CLAIM CONTACT INFORMATION:

General Services Department

Attn: Carli O'Connel

500 Poplar View Parkway

Collierville, TN 38017

Email: insuranceclaims@colliervilletn.gov

T: (901) 457-2250

F: (901) 457-2258

INSURANCE IDENTIFICATION CARD

STATE	COMPANY	
TENNESSEE	PUBLIC ENTITY PARTNERS	
COMPANY NUMBER	POLICY NUMBER	
NA-RISK POOL	PLI-0070-20	
	EFFECTIVE DATE	EXPIRATION DATE
	07/01/2019	07/01/2020
DESCRIPTION OF AUTOMOBILE	ALL OWNED OR HIRED VEHICLES OPERATED BY THE INSURED	

AGENCY
DIRECT WITH PUBLIC ENTITY PARTNERS
5100 MARYLAND WAY
BRENTWOOD TN 37027

INSURED
TOWN OF COLLIERVILLE
500 POPLAR VIEW PKWY
COLLIERVILLE TN 38017

An insurance policy has been issued that satisfies the requirements of Tennessee Financial Law

**THIS CARD SHOULD BE KEPT IN THE INSURED
VEHICLE AND PRESENTED UPON DEMAND**

**IN CASE OF ACCIDENT: Report all accidents to your agent
or Public Entity Partners as soon as possible.**

Always obtain the following information at the accident scene:

1. Name and address of each driver involved in the accident.
2. Name of insurance company and policy number for each vehicle involved.
3. Name and badge number of responding police officer.
4. Police accident report number if available.

The insured may duplicate this card as needed to supply any covered auto.

Ed. 7/1/2012

ACCIDENT FORM

DATE: _____ NAME: _____

DEPARTMENT: _____ VEHICLE #: _____ TIME OF ACCIDENT: _____

TOC POLICE REPORT FILE #: _____

LOCATION OF ACCIDENT: _____

(PLEASE USE THE BACK OF THIS FORM FOR DIAGRAM DRAWINGS)

OTHER VEHICLE INFORMATION

NAME OF DRIVER: _____ D/L#: _____

NAME OF OWNER: _____

ADDRESS OF OWNER: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION

COMPANY: _____

POLICY #: _____

ADDRESS OF INSURANCE COMPANY: _____

WITNESS INFORMATION

NAME: _____

ADDRESS: _____

NAME: _____

ADDRESS: _____

USE ADDITIONAL SHEETS IF MORE WITNESSES ARE AVAILABLE

REVISED: 13 May 2013



SUPERVISOR'S INVESTIGATIVE REPORT

NAME: _____ AGE: _____ TIME: _____ DATE: _____

DEPARTMENT: _____ SHIFT: _____ TITLE: _____ HOW LONG: _____

WHAT HAPPENED? Describe what took place or what caused you to begin this investigation.

WHY IT HAPPENED? Get all the facts by studying the job and situation involved. Question WHAT - WHERE - WHEN - WHO - HOW

WHAT SHOULD BE DONE?

Determine which of the 9 items under EMP require attention:	EQUIP <small>(Select)</small>	MATERIAL <small>(Select)</small>	PEOPLE <small>(Select)</small>
<input type="checkbox"/> Arrange	<input type="checkbox"/> Use	<input type="checkbox"/> Place	<input type="checkbox"/> Place
<input type="checkbox"/> Maintain	<input type="checkbox"/> Process	<input type="checkbox"/> Handle	<input type="checkbox"/> Train
		<input type="checkbox"/> Lead	

WHAT HAVE YOU DONE THUS FAR? Take or recommend action depending upon your authority. Follow-up - Was the action effective?

WILL THIS IMPROVE OPERATIONS? Objective: Eliminate job hindrance.

FILED BY: _____ DATE: _____

REVIEWED BY: _____ DATE: _____

For Reference Only

APPLICABILITY OF FINANCIAL RESPONSIBILITY LAW TO CITY OWNED MOTOR VEHICLES

T.C.A. 55-12-139(b)(3) provides in part "the motor vehicle being operated at the time of the violation was owned by ... this state or any political subdivision thereof, and that such motor vehicle was being operated with the owner's consent."

Our interpretation of this subsection is that an operator of a motor vehicle may comply with the statute by providing evidence of ownership by the municipality such as a vehicle registration.

In the unlikely event that this evidence does not satisfy the officer, subsection (e) provides that "on or before the court date, the person so charged may submit evidence of compliance with this section at the time of the violation" and the charge of failure to provide evidence of financial responsibility may be dismissed.

The clear intent of this statute is to exempt vehicles owned by the state and its political subdivisions, including municipalities, from the documentation requirements set out in subsections (b)(1) and (2).

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**



CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS. IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).		
	CLAIMS ADM CLAIM # (INSURER CLAIM #)						
	OSHA LOG CASE #						
	NAME OF INSURANCE CARRIER Public Entity Partners		CARRIER FEIN 62-1074045				
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)		FEIN OF CLMS ADM 59-2863407				
	CLAIMS ADJUSTER NAME Fax#1-877-469-7611		CLMS ADJ PHONE # 800-288-0829				
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 5100 Maryland Way				CITY Brentwood	STATE TN	ZIP 37027	
EMPLOYER	EMPLOYER NAME Town of Collierville		EMPLOYER FEIN 62-6000268		SIC CODE	PHONE NUMBER 901-457-2290	
	EMPLOYER ADDRESS LINE 1 AND LINE 2 500 Poplar View Parkway				NATURE OF BUSINESS Municipality		
	CITY Collierville	STATE TN	ZIP 38017	INSURED REPORT #			
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME	
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE		
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION		
	ADDRESS LINE 1 & 2						
	CITY	STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	NCCI CLASS CODE	
	SSN	DATE OF BIRTH	DATE OF HIRE				
WAGE	WAGE \$	PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO	
						FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM		
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE	CAUSE OF INJURY CODE	
	DATE CLAIM ADM NOTIFIED OF INJURY		HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.				
	DATE LAST DAY WORKED						
	DATE DISABILITY BEGAN						
	RETURN TO WORK DATE (IF APPLICABLE)						
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER _____ SISTER TOTAL # DEPENDENTS <input type="checkbox"/> WIDOWER _____ DAUGHTER _____ BROTHER <input type="checkbox"/> MOTHER _____ SON _____ HANDICAPPED CHILD				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO						
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)					COUNTY OF INJURY		
CITY			STATE		ZIP		
TREATMENT	PHYSICIAN NAME			HOSPITAL OR OFF SITE TREATMENT NAME			
	ADDRESS LINE 1 AND 2			ADDRESS LINE 1 AND 2			
	CITY	STATE	ZIP	CITY	STATE	ZIP	
	INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL	<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME	PHONE NUMBER		

EMPLOYEE PROCEDURES AND INFORMATION FOR ON THE JOB INJURIES

You have the right to a safe workplace!

You have the right to raise a safety concern with the Town or confidentially with OSHA directly, or report a work-related injury or illness without being retaliated against. You have the right to receive information and training on job hazards, including all hazardous substances in your workplace. You have the right to request an OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions, and OSHA will keep your name confidential. You have the right to file a complaint with OSHA within 30 days if you feel you have been retaliated against for using your rights. You have the right to see any citations issued to the Town of Collierville by OSHA and you can request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

>Employees must report all accidents, injuries, illnesses, or near misses while at work to their supervisor/department directors as soon as possible, but not later than two (2) hours after the occurrence to ensure that you receive immediate care if necessary.

>Your supervisor (or designee) must complete a First Report of Injury form AND the Employee's Choice of Physician form. You must choose a physician from the "Employees Choice of Physician" form, and sign/date indicating the physician that you have chosen no later than 24 hours after advising of the injury.

>If you are issued a prescription from one of the panel physicians, you must refer to the information in your workers compensation packet for OPTUM. You may use any pharmacy in that provider network (listed on the OPTUM instruction document) and give the pharmacy your name, social security number and date of injury. The pharmacy will keep the letter from your packet and you may return to that same pharmacy for any subsequent prescriptions or refills related to your injury, at no charge to you. DO NOT PRESENT YOUR HEALTH INSURANCE CARD FOR THIS PRESCRIPTION. IF YOU ARE UNABLE TO USE ONE OF THE PHARMACIES IN THE NETWORK, YOU MUST PAY FOR THE PRESCRIPTION IN FULL AND FILE FOR A REIMBURSEMENT FROM PUBLIC ENTITY PARTNERS.

>If your panel physician indicates that you need a specialist or physical therapy, you should have the doctor fax their order to H.R. at 901-457-2295, or you may bring the order to H.R. That order will be sent to Public Entity Partners and Public Entity Partners will assign a panel of specialists for you to choose from. Public Entity Partners will make all specialist appointments.

You will indicate (by separate form) your decision to use your personal leave totals for the periods of time that you do not receive workers compensation benefits. Some of the instances that you could use personal leave are as follows:

>The date of your injury, and the first 7 calendar days following your injury that are not compensable through Public Entity Partners.

>Personal leave can be used for the 33 1/3% that Public Entity Partners does not pay. Public Entity Partners only compensate an injured worker at 66 2/3 % of the employee salary. That will leave approximately 15 hours per week unpaid if you choose not to supplement with your personal leave totals.

>Any doctor appointments, physical therapy appointments, and out-patient testing appointments made and kept during work hours after you've been returned to work are not compensable through Public Entity Partners.

Your time off work will run concurrently with FMLA, whether paid or unpaid.

ALSO REMEMBER.....You are prohibited from engaging in secondary employment while on light duty, or removed from duty. Personnel Policies and Procedures Manual, Chapter 14, Section 3, #5: "Approval for outside employment is revoked during an employee's disability or limited duty status". Strict adherence to this rule is required or you will be subject to disciplinary action.

Revised 10-13-16
Revised 4-1-17



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE:** Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer Town of Collierville Date of Injury _____

Employer Contact: Cindy Greer or Shanda Ford Phone: 901-457-2290 Email: cgreer@collierville.tn.gov, sford@collierville.tn.gov

1. Physician Name: Mark Vlasak - Vlasak Internal Medicine Phone: 901-853-5551

Address: 1164 W. Poplar Ave. City: Collierville State: Tn Zip: 38017

2. Physician Name: Ara Hanissian-Hanissian Health Care Phone: 901-853-2021

Address: 574 Greentree Cove, #101 City: Collierville State: Tn Zip: 38017

3. Physician Name: Joseph Holley - First Choice Care Phone: 901-854-5771

Address: 472 W. Poplar Ave, #101 City: Collierville State: Tn Zip: 38017

4. Physician Name: Monica Griffin-Baptist Minor Medical Phone: 901-753-7686

Address: 670 N. Germantown Pkwy #18 City: Cordova State: Tn Zip: 38018

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____



TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____ having filed a claim for workers' compensation benefits, do hereby authorize

(Name of Medical Provider)

To furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation.

I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20 ____ .

Patient

Social Security last four numbers

Witness

Compensation Consent Form

Date: _____

To: _____

RE: Workers Compensation Injury

Please be advised that your recent workers compensation absence(s) from work are managed in the following manner:

>The first 7 days off work after your injury will be unpaid.

>Days 8-13 off work after your injury will be reimbursed through Public Entity Partners at a rate of 66 - 2/3% of your salary.

>Days 14 until the date of your return to work will be reimbursed through Public Entity Partners at a rate of 66 - 2/3% of your salary. After day 14, the time off work for days 2-7 will be reimbursed by Public Entity Partners at 66 - 2/3%. The first day of your injury will never be reimbursed by Public Entity Partners.

If you have leave balances such as sick, vacation or compensatory time, you may use these totals to make up the difference between the 66 - 2/3% and the 100% of your wages while off work on a work related injury. If you choose to use your leave totals to supplement the 66 - 2/3%, when Public Entity Partners sends the reimbursement check to the Town for you, you will be required to endorse the check, return it to Human Resources and it will be deposited back to your department's payroll account.

EXAMPLE: For a regular 40 hour work week, you would use 15 hours of your leave balance in the following order with no deviations: 1st – sick, 2nd – vacation and 3rd – compensatory time. The Town would also consider the upcoming Public Entity Partners indemnity payment to be 25 hours, giving you a total of 40 hours for that week.

If you choose not to use your leave totals, your Town salary will stop on the date of your injury. You will be responsible for paying your insurance premiums to Human Resources on your normal pay dates (contact Human Resources for your premium amounts and the due dates). Non-payment of premiums could result in coverage/claims being pended, and in some instances your coverage could be cancelled. You would generally receive the Public Entity Partners indemnity check up to 14 days after your time off work began.

Remember that your workers compensation absence runs concurrently with FMLA (See Chapter 9 of the Personnel Policies and Procedures).

I authorize the use of my leave totals to supplement my workers compensation absence:

Signature: _____ Print Name: _____ Date: _____

I do not authorize the use of my leave totals to supplement my workers compensation absence:

Signature: _____ Print Name: _____ Date: _____



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. *Please note this First Fill card is valid for 10 days from initial use. However, if your claim is accepted and set up with Public Entity Partners, you will need to process your prescriptions using your permanent pharmacy card, even if it is within that 10 day period.*

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, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-940-4459 or visit tmesys.com.

If you have any questions or need assistance, please contact or have the pharmacy contact Optum at:



1-866-940-4459

Approved Pharmacies:
Walmart
Kroger
Target/CVS
Walgreens
Benevere

	Public Entity Partners Workers Compensation Program
WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM	
Public Entity Partners 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
1-866-940-4459**

	NDC	or	Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TNMLFF		

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.