



since 1989

A.I.M. Mutual Insurance Company  
Associated Employers Insurance Company  
Massachusetts Employers Insurance Company  
New Hampshire Employers Insurance Company



Claim **Kit**

in  
partnership  
with  
you



A.I.M. Mutual Insurance Company  
Massachusetts Employers Insurance Company  
New Hampshire Employers Insurance Company  
Associated Employers Insurance Company

On behalf of the A.I.M. Mutual Insurance Companies, I welcome you as a policyholder.

As your new workers' compensation insurance carrier, we ask that you report all accidents to us as soon as possible after they occur. Once a claim is reported to us, we complete a First Report of Injury (Form WCB-1) on your behalf and file it with the State of Maine Workers' Compensation Board when the employee has missed one day's worth of work.

Your prompt notification, together with a complete accident report, will help us handle your claims fairly and efficiently. Timely reporting will also help you avoid late-reporting fines that accrue when the WCB-1 is not completed within seven days of the employer receiving notice—or having knowledge of—an injury which requires services of a health care provider.

This Claim Kit provides you with claim reporting procedures, commonly used forms, and a Workers' Compensation Temporary Prescription ID card. Please feel free to contact us at any time with your questions or service requests.

Sincerely,

Laura Parsons, WCLA, FCLA  
Director of Claim



54 Third Avenue, Burlington, MA 01803

## Workers' Compensation Maine Claim Reporting Options

**In the event of a serious accident, call us immediately at 1-866-270-3354  
(toll free 24-hour/7 day a week claim reporting)**

All injuries, including first aid only, should be promptly reported to A.I.M. Mutual Insurance Companies. Failure to report claims in a timely manner could expose your company to fines and penalties. While the preferred method is online reporting, there are several different ways to report your workers' compensation claims to us. Regardless of which method you choose, we will set up a claim and, when required, file the First Report of Injury (Form WCB-1) with the State of Maine Workers' Compensation Board. Additionally, copies of the WCB-1 will be sent to you and to the employee when applicable.

### **On-Line:**

Log on to [www.aimmutual.com](http://www.aimmutual.com). Select Report A Claim / Report A Claim ME.

You will be prompted to answer a series of questions similar to the information necessary to complete a Form WCB-1. After answering all of the questions and clicking on SEND, you will receive a message stating your claim has been submitted. It will also state that a Claim Acknowledgement letter containing the claim number and assigned claim representative will be mailed to your company after registration has been completed.

### **By Phone:**

**Report claims by calling toll free: 1-866-270-3354.**

**This line is established for reporting new claims only and facilitates the initial claim reporting process.** Please have your policy number on hand prior to calling. You will receive a confirmation letter, followed by a claim acknowledgment letter including the name of the Claim Representative assigned to your case.

***After the initial claim report: Please direct ongoing claim and service inquiries to your Claim Representative at our toll free telephone number: 1-800-876-2765***

### **By Fax:**

For **all** claims, complete and fax the Employer First Report of Occupational Injury or Disease (Form WCB-1) to us at **1-781-270-5599**.

### **By Mail:**

Mail the completed Form WCB-1 to A.I.M. Mutual Insurance Companies, Attn: Claim Department, 54 Third Avenue, P.O. Box 4070, Burlington, MA 01803-0970



## **State of Maine** **Workers' Compensation Claim Reporting Procedures**

It is important the instructions in these procedures be followed exactly as outlined. Prompt filing of the correct forms with all the necessary information helps speed necessary claim investigations and the proper payments of benefits when due. **LATE FILINGS OR LATE PAYMENTS MAY ALSO RESULT IN PENALTIES IMPOSED ON YOUR COMPANY AND/OR A.I.M. MUTUAL INSURANCE COMPANIES AS YOUR INSURER.**

### **Keep in mind:**

- **If it's a serious accident, call us immediately: 1-866-270-3354**
- **We will file the Employer First Report of Injury (Form WCB-1) with the State of Maine Workers' Compensation Board.**

**If you need additional forms, they may be requested from A.I.M. Mutual Insurance Companies at 1-800-876-2765, Claim Services Department** or downloaded from [www.aimmutual.com](http://www.aimmutual.com) or the State of Maine Workers' Compensation Board website: <https://www.maine.gov/wcb/forms/index.html>

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### **Applicable Forms**

#### ***For any job-related claim:***

- |    |            |   |
|----|------------|---|
| 1. | Form WCB-1 | Employer's First Report of Occupational Injury or Disease |
|----|------------|---|

#### ***Additional forms for any lost time claim:***

- |    |              |   |
|----|--------------|---|
| 1. | Form WCB-220 | Workers' Compensation Medical Authorization |
| 2. | Form WCB-2   | Wage Statement                              |
| 3. | Form WCB-2B  | Fringe Benefit Worksheet                    |

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### **Employers' Responsibility for Reporting an Injury**

1. You must report any injury that results in medical care or an absence of work within 7 days of notice or having knowledge of the injury to A.I.M. Mutual Insurance Companies (A.I.M. Mutual, AEIC). Filing a claim does not mean it's automatically an accepted workers' compensation case. We will complete an investigation to determine compensability if appropriate.
2. First-aid only injury claims also must be reported. We will report the claim to the State of Maine Workers' Compensation Board on your behalf when warranted.
3. A.I.M. Mutual will assign an adjuster to investigate your claim and either accept or deny it within 14 days of your having notice or knowledge of the injury. Send any information that you have regarding the injury or incident directly to your A.I.M. Mutual adjuster to assist him or her in the investigation.
4. Once you have been notified that the injured worker has a work capacity, keep A.I.M. Mutual aware of any available work that you have for the injured employee. Be sure to notify A.I.M. Mutual as soon as the injured employee returns to work.

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

### REASON FOR REPORT (check all that apply)

2a. <input type="checkbox"/> LOST TIME - ONE OR MORE DAYS	2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. <input type="checkbox"/> FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY	
3. <input type="checkbox"/> LOST EARNINGS BUT NO LOST TIME	4. <input type="checkbox"/> MEDICAL/HEALTH CARE	6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY	
6a. <input type="checkbox"/> OCCUPATIONAL DISEASE	6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY	7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY	
7a. <input type="checkbox"/> CORRECT PRIOR REPORT	7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY		

### EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	10. EMPLOYER NAME:		
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one)  **INSURER**                       **THIRD PARTY ADMINISTRATOR (TPA)**                       **SELF-ADMINISTERED EMPLOYER**

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:	21. INSURER FILE NUMBER:		
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

### EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:	35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY	
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: \$	41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS:		

### CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY
DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	46. TIME OF INJURY (e.g. 1:10 p.m.):	47. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(S) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):	

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):
WAS ACTIVITY PART OF NORMAL JOB DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	

53. HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO:	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )
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### PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY
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THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.  
WCB-1 (eff. 1/1/13)

**WAGE STATEMENT**  
**STATE OF MAINE**  
**WORKERS' COMPENSATION BOARD**  
**27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**

1. INSURER FILE NUMBER:		6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS): <b>XXX -XX-</b>		7. WCB FILE NUMBER:		
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		11. ADDRESS-NUMBER AND STREET:				
4. INSURER NAME:		12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:	
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:			
18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): _____ NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.			YES <input type="checkbox"/>	NO <input type="checkbox"/>	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))	
			YES <input type="checkbox"/>	NO <input type="checkbox"/>		

**&S" @GH; FCGG95FB-B; G: CF '957 < 'K 99?.** .....

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			K ? 'C: ' -B>I FM		
17			35			&S" HCH5 @ ..... 95FB-B; G		
18			36			&S"; FCGG5J9F5; 9' ..... 'K 99? @MK 5; 9		

23. COMMENTS:

24. PREPARER NAME (TYPE OR PRINT):		25. TELEPHONE NUMBER: ( )		26. DATE MAILED:	
E-MAIL ADDRESS:		TOLL-FREE NUMBER: ( )		MM / DD / YYYY	

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.  
WCB-2 (eff. 1/1/13)

**FRINGE BENEFITS WORKSHEET**  
**STATE OF MAINE**  
**WORKERS' COMPENSATION BOARD**  
**27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**

1. INSURER FILE NUMBER:		6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		11. EMPLOYEE ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:		12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

**PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).**

**NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.**

18. Fringe Benefit	Provided	Continues while Employee is out of work	Date Benefits End	Weekly Cost of Benefits to Employer
Health Benefits (inc. insurance)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Dental Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Disability Insurance (inc. short and long term)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
401K	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Life Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Education/Training	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Pension	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Other (please list):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Other (please list):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$

19. PREPARER NAME (TYPE OR PRINT):		20. TELEPHONE NUMBER: ( )	21. DATE MAILED:
E-MAIL ADDRESS:		TOLL-FREE NUMBER: ( )	MM / DD / YYYY



# State of Maine Workers' Compensation Board

## Limited Release of Medical/Health Care Information

Name: \_\_\_\_\_ SSN (last 4 digits): XXX-XX-

Date Birth: \_\_\_\_\_ Date of Injury/Illness: \_\_\_\_\_

**Notice to employer/insurer/employee representative:** You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Abuses may result in penalties.

**Notice to employee:** The employer/insurer contends your health care provider's medical records, regardless of the date of injury, meaning all records relating to the diagnosis, treatment and care, including X-rays, related to the following body part(s) and/or condition(s):

\_\_\_\_\_ are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including X-rays, of the body part(s) and/or condition(s) listed above. This release authorizes the release of records dating from \_\_\_\_\_ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

**Voluntary:** I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

**Limited:** I understand this form gives my health care providers permission to release only those health records related to the body part(s) and/or condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

**Redisclosure:** I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

**Revocable:** I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

**This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance abuse; HIV/Aids and sexually transmitted diseases.**

I authorize release of my medical records to: \_\_\_\_\_  
(Name of Recipient)

Address of Recipient: \_\_\_\_\_  
\_\_\_\_\_

Format Requested (circle one): **Electronically (if available):** \_\_\_\_\_ Fax to: \_\_\_\_\_

Mail to : \_\_\_\_\_

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).



## **Express Scripts Pharmacy Program for Injured Workers**

As part of our workers compensation medical management services, we ask injured workers to use a pharmacy program through Express Scripts, Inc. (ESI). ESI is a pharmacy benefit management company that is uniquely set up to provide prescription medications for work-related injuries.

Injured employees will be notified by mail about the pharmacy program and how it works shortly after their claim has been approved. They will also receive a prescription identification card; **the card is valid only for prescriptions related to the specific, approved work injury.** Injured employees will be asked to use an Express Scripts affiliated pharmacy to fill their injury-related prescriptions.

Express Scripts also offers a mail service program, which employees will find convenient for refilling maintenance (long-term) prescription medications. I'm sure you are familiar with the cost benefits of a mail order prescription program, and we ask that you encourage injured workers to take advantage of this service. Most prescriptions are filled within 48 hours of receipt and mailed directly to the injured employee's home. Injured employees can sign up for the mail service program through ESI by phone or by mail.

Additional benefits of the program include 24-hour access to a registered pharmacist via a toll-free number and an extensive network of pharmacies to choose from. Express Scripts offers significant savings of up to 35% over fee schedules and usual and customary charges, and the program will expedite claim processing and payment. Injured employees will incur no out-of-pocket expenses.

Injured workers will receive a condensed list of chain pharmacies in the network on their prescription card information sheet. Most major pharmacies such as CVS, Walgreens and Rite Aid are affiliated with Express Scripts. For a full listing, injured workers can go to [www.express-scripts.com/NATPLSNOFORM/index.html](http://www.express-scripts.com/NATPLSNOFORM/index.html) or call Express Scripts at 1-800-945-5951. While injured employees may use a non-affiliated pharmacy, we strongly recommend they use a pharmacy within the Express Scripts network and the mail order service to realize the program benefits.

Please call the Express Scripts Workers Compensation Service Center at 1-800-945-5951 with any questions you may have. The toll free service is available 24 hours a day, seven days a week. As always, thank you for working with us to enhance our claim service.

Sincerely,



Laura Parsons, WCLA, FCLA  
Director of Claim

# Workers' Compensation 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 workers' compensation prescriptions (based on the guidelines established by your employer).

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

## Atencion 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 800.945.5951.

## »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from 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 A4
- 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  
(enter in PA field in the format YYYYMMDD)

### Express Scripts

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 #: AIM WORKS

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

**NOTE:** This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.



EXPRESS SCRIPTS®