DIVERSIFIED CARE MANAGEMENT

Re: Enclosed Workmen's Compensation Claim Information

This information is being forwarded to in regard to the work related injury that you reported to your supervisor.

All required information is marked with an X and must be completed and returned by fax as soon as possible to 724-584-5097. Your claim may be delayed or denied if the requested information is not submitted right away.

Any form that does not have an X, to indicate a request for information or a signature, is for you to keep. Some of these documents will be presented to the doctor or pharmacy and the instructions are on each form. Please read them all carefully.

Your claim will not be submitted until this paperwork has been returned to the Business Office at 9515 Goehring Rd, Cranberry Township, PA 16066 by faxing to 724-584-5097. Delay in submitting the paperwork could result in denial or delay in payment of expenses incurred.

Please direct any questions you have to 724-584-5100 x 133.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

X EMPLOYEE SOCIAL SECURITY NUMBER

X DATE OF INJURY
MONTH DAY YEAR

X EMPLOYEE FIRST NAME

X EMPLOYEE LAST NAME

X STREET ADDRESS

X CITY X STATE X ZIP CODE

X COUNTY X PHONE NUMBER

X EMPLOYEE:
MALE MARRIED
X FEMALE SINGLE

X NUMBER OF DEPENDENTS X DATE OF BIRTH
MONTH DAY YEAR

X OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN) EMPLOYMENT STATUS FT = Full-time PT = Part-time SL = Seasonal VO = Volunteer ZZ = Other

X EMPLOYER

EMPLOYER'S ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES
NO

X TIME EMPLOYEE BEGAN WORK
AM
PM

X TIME OF OCCURRENCE
AM
PM

344 1197-1

X LAST DAY WORKED
MONTH DAY YEAR

X DATE DISABILITY BEGAN
MONTH DAY YEAR

X DATE EMPLOYER NOTIFIED
MONTH DAY YEAR

X DATE RETURNED TO WORK
MONTH DAY YEAR

X DATE OF HIRE
MONTH DAY YEAR

X CONTACT FIRST NAME

X CONTACT PHONE NUMBER

X CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

LIBC 344

X TYPE OF INJURY CODE | X PART OF BODY AFFECTED CODE | CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

X TYPE OF INJURY OR ILLNESS

X PARTS OF BODY AFFECTED

X CAUSE OF INJURY

X DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?	X IF OUT OF STATE, SPECIFY STATE OF INJURY	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES		YES	YES
NO		NO	NO

X ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

X HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

X IF FATAL, GIVE DATE OF DEATH

MONTH DAY YEAR

X PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP

X

HOSPITAL NAME:

STREET

CITY STATE ZIP

POLICY/SELF INSURED NUMBER:

X INITIAL TREATMENT: Select One:

- NO MEDICAL TREATMENT
- MINOR BY EMPLOYEE
- CLINIC / HOSPITAL
- PANEL PHYSICIAN
- EMPLOYEE PHYSICIAN
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM:

MONTH DAY YEAR

POLICY PERIOD TO:

MONTH DAY YEAR

X WITNESS FIRST NAME

X WITNESS PHONE NUMBER

X WITNESS LAST NAME

X

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

DATE PREPARED

X

MONTH DAY YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

AmeriHealth CASUALTY SERVICES
P.O. Box 3400
Pittsburgh, PA 15230-3400

AmeriHealth
CASUALTY SERVICES

Workers' Compensation Information

(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.

AmeriHealth
CASUALTY

P. O. Box 3460 ♦ Pittsburgh ♦ Pennsylvania 15230-3460 Phone: 800-719-2889 ♦ Fax: 800-929-0534

What Do I Do If My Employee Gets Hurt At Work?

Even at the safest of workplaces, accidents can occur. Here is what to do if one of your employees if injured on the job:

1. The employee should notify his/her supervisor immediately. The supervisor will complete an accident report and ensure that medical care with a panel doctor is rendered if needed. The supervisor is responsible for completing the workers' compensation claim form. The completed form should be faxed to the number on the top of the form along with a copy of the acknowledgement statement that the employee signed when his benefits were explained to him/her. This acknowledgment statement is located at the bottom of the "What Happens If I Get Hurt At Work" form, and a copy with the employee's signature should be in his/her personnel file.

2. For emergency care, you should call 911 or have someone accompany the injured employee to the closest emergency room. Any follow-up care should be provided by one of the facilities on your workers' compensation panel list.

3. For non-emergencies, the employee should choose one of the panel doctors. You should give the injured employee a copy of the panel at this time.

4. According to Pennsylvania's Workers' Compensation Act, injured employees must treat with a panel provider for the first **90 days**. Any unauthorized treatment or treatment outside the panel will be the employee's financial responsibility and may jeopardize the workers' compensation claims.

5. The panel physician will evaluate the employee and determine if further testing is needed. He/She will also determine if it is safe for the employee to return to work. If the employee is not returned to work, he/she must notify you **immediately**.

6. The injured employee must keep scheduled appointments with the chosen treatment provider. If, for any reason, the employee is unsatisfied with the care he/she is receiving, please call us at **1-800-719-2889**.

AmeriHealth
CASUALTY

P O Box 3460 • Pittsburgh • Pennsylvania 15230-3460 Phone 800-719-2889 • Fax 800-329-0531

What Happens If I Get Hurt At Work?

Even at the safest of workplaces, injuries can occur. Here is what to do if you are injured at work:

1. Notify your supervisor immediately. He/She will ensure that you receive medical care if you need it and will file a workers' compensation claim on your behalf.
2. For emergency care, you should go to the closest emergency room. Any follow-up care should be provided by one of the approved facilities on your workers' compensation panel list. For non-emergencies, choose one of the panel doctors. If you do not have a panel list, see your supervisor or Human Resources.
3. According to Pennsylvania's Workers' Compensation Act, you must treat with a panel provider for the first **90 days**. Any unauthorized treatment or treatment outside the panel will be your financial responsibility and may jeopardize your claim. After 90 days you may treat with a provider of your choice but you **must** notify your employer in writing within five (5) days of the first visit or the treatment becomes your financial responsibility.
4. The panel physician will evaluate your injury and determine if it is safe for you to return to work. If you are not returned to work, notify your supervisor immediately.
5. You must keep scheduled appointments with your treatment provider. If, for any reason, you are unsatisfied with the care you are receiving, please call AmeriHealth at 1-800-719-2889. After regular business hours, you will be transferred to our answering service. Our claims adjuster and medical case manager are available to discuss your claim and to ensure you receive reasonable and necessary care for your work injury.

Acknowledgement

In compliance with Pennsylvania's Workers' Compensation Act, I acknowledge that I have been informed of my rights and have received a copy of the designated health care provider panel which was designed by AmeriHealth Casualty Services for my employer, _____.
(Name of Company)

I understand that any work related injury or illness is to be immediately reported to my supervisor and, with the exception of true emergency care, I am to treat with one of the providers on the panel for the first 90 days after my injury. I understand that if I treat outside this panel without proper authorization, my employer has the right to refuse payment for that care. Should I still require treatment after 90 days, I understand that I may choose a non-panel provider but that I must notify my employer within five days of the first visit to this provider. I understand that if surgery is recommended, I may seek a second opinion with a physician of my choosing. If the second opinion differs, I may choose the course of treatment I wish to follow but that treatment is to be rendered by one of the panel providers if I am within the first 90 days after injury.

X_____ X_____
Signature Date

Copy 1: Human Resources Copy 2: Employee

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at 425 Sixth Ave Suite 550 Pittsburgh, PA 15219 for you to view. Also, you may get a copy of this list ~~from~~ by calling 724-584-5100 x 133.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☒ TIME OF HIRE ☒ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: X _____ DATE: X _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

AmeriHealth Casualty Services
P.O. Box 3466
Pittsburgh, PA 15230-3466

AmeriHealth
CASUALTY SERVICES

Authorization to Release Medical Information

I hereby authorize any physician, nurse or other health care professional who has attended me, or any hospital at which I have been confined to furnish to AmeriHealth Casualty Services or an authorized representative, any and all information which may be requested regarding my physical or mental condition and treatment rendered therefore and, if necessary, to allow them or any physician appointed by them to examine any x-rays take of me or records regarding my physical or mental condition or treatment.

A photocopy of this instrument may be used instead of the original.

La Autorización a Soltar a Informacion Médico

Por este medio autorizo a cualquier médico, cualquiera enfermera u otro profesional de cuidado de la salud que me ha asistido a mí, o cualquier hospital en el cual he estado recluido para proveer para AmeriHealth Casualty Services o un representante autorizado, cualquier información que puede ser demandado referente a mi condición física o mental y que mi tratamiento dado por esto y, si necesario, a permitirlos a ellos o cualquier médico señalado por ellos a examinar cualquier tome radiográfias de mí o los registros estimando mi condición física o mental o el tratamiento.

Una fotocopia de esta forma puede ser usada en lugar del original.

X _____ _____
Date — La fecha

X _____ _____
Employee's Name (Print) — Nombre del Empleado (la Impresión)

X _____ _____
Employee's Signature — Signatura del Empleado

X _____ _____
Employee's Date of Birth — Fesha de Nacimiento del Emploado

X _____ _____
Employee's Social Security Number — El Numero de Seguro Social del Empleado

X _____ _____
Employee's Home/Cell Phone Number — El Número de Teléfono de Casa/Celular del Empleado

AmeriHealth®
CASUALTY SERVICES

PROGRAM FOR WORK RELATED INJURIES

Employer Diversified Care Management

Employee _____

Injury _____

Insurance Verification @ 800-297-2726

For MRI Testing – Contact One Call Medical @ 877-302-4693

Present this card to the physician's office when you receive medical care for a **work related** injury.

You must report your injury to your supervisor immediately.

Medical bills and reports should be faxed or mailed within 24 hours to:

AmeriHealth Casualty Services
P.O. Box 3460
Pittsburgh, PA 15230-3460
Telephone: 1-800-297-2726
Fax: 1-800-381-5561

Pharmacy Services – Contact myMatrixx @ 877-804-4900

GREAT LAKES BEHAVIORAL RESEARCH INSTITUTE - 16066

WORKERS' COMPENSATION PROGRAM: DESIGNATED HEALTH CARE PROVIDERS

THE FOLLOWING PROCEDURE MUST BE FOLLOWED IN CASE OF WORK RELATED INJURY OR ILLNESS:

A. IMMEDIATELY REPORT THE INJURY TO YOUR SUPERVISOR.

Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. **Supervisors must promptly report injuries to the appropriate personnel office.**

B. OBTAIN MEDICAL CARE FROM A PROVIDER LISTED BELOW.

Provider	*Address*	*Phone Number*	*Specialty*
1. Huwaida Mansour, MD	Ohio Valley General Hospital Business Fit, 27 Heckel Road Suite 210 McKees Rocks. PA 15136	412-777-6369	OCCUPATIONAL MEDICINE
2. Shadrach H. Jones, MD	Health Assistance Program For Personnel Industry, 20130 Route 19 Suite 2200 Cranberry Township. PA 16066	724-772-5400	OCCUPATIONAL MEDICINE
3. Michael Rowe, DO	Concentra Medical Center, 120 Lytton Avenue Suite 275 Pittsburgh. PA 15213	412-621-5430	OCCUPATIONAL MEDICINE
4. Darren Paulovich, MD	Concentra Medical Center, 4390 Campbells Run Road Pittsburgh. PA 15205	412-429-9675	OCCUPATIONAL MEDICINE
5. John J. Honacki, DC	20280 Route 19 Unit 2 Cranberry Township. PA 16066	724-776-5095	CHIROPRACTIC
6. One Call Care Dental and Doctor	One Call Care Dental and Doctor, For the nearest location, please call the toll free number.	888-539-0577	DENTIST
7. Paul E. Collier, MD	Greater Pittsburgh Surgical Alliance, 701 Broad Street Suite D Sewickley. PA 15143	412-749-9868	GENERAL SURGERY
8. Hospital	For Emergency Services, please go to the nearest hospital		HOSPITAL (FOR EMERGENCY SERVICES ONLY)
9. Howard J. Senter, MD	4815 Liberty Avenue Suite 448 Pittsburgh. PA 15224	412-682-6800	NEUROLOGICAL SURGERY
10. Kevin D. Clark, MD	Ophthalmology Associates, 1099 Ohio River Boulevard Sewickley. PA 15143	412-741-6776	OPHTHALMOLOGY
11. Stephen Thomas, MD	Greater Pittsburgh Orthopaedic Associates, 144 Emeryville Drive Suite 130 Cranberry Township. PA 16066	412-262-7800	ORTHOPEDIC SURGERY
12. myMatrixx	For the nearest location, please call the toll free number.	877-804-4900	PHARMACY
13. Select Medical / NovaCare	Select Medical / NovaCare, For the nearest location and to make an appointment, please call the toll free number.	800-770-6682	PHYSICAL THERAPY
14. RIN / One Call Care Management Company	RIN / One Call Care Management Company, For the nearest location and to make an appointment, please call the toll free number.	800-453-0574	RADIOLOGY

C. MEDICAL EMERGENCY:

If you are faced with a medical emergency, **you may secure initial emergency treatment from any of the below mentioned emergency facilities or any other emergency facility**. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. IF YOU CHOOSE TO TREAT WITH AN OUT OF STATE PROVIDER, YOU MAY BE SUBJECT TO BALANCE BILLING.

E. FOR MEDICAL TREATMENT TO BE PAID BY YOUR EMPLOYER:

1. **You must select one of the physicians or physician groups listed above.**
2. **You must continue** to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, **for Ninety (90) days from the date of your first visit**. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i)
3. **After Ninety (90) days**, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. **If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.**
4. Your bills will be paid if your physician or health care provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). **You** must notify the new provider that these reports are to be submitted to the following address:

ACS - PITTSBURGH OFFICE
AmeriHealth Casualty Services
PO Box 3460
Pittsburgh, PA 15230
1-800-297-2726
05/20/2014

- **For medical practice groups, all providers are eligible to render medical services**

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

BUREAU OF WORKERS' COMPENSATION

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, are shown below.

Employer Name: Great Lakes Behavioral Research Institute **Date Posted:** 4/1/2014

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:
Companion Property & Casualty Insurance Company

Address: 1700 Market St., Suite 700
Philadelphia, PA 19103

Telephone Number: 215-587-1901

Insurer's Bureau Code: 2328

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

Name of TPA (Claims administrator):
Business Office

Address: 9515 Goehring Rd
Cranberry Twp, PA 16066

Telephone Number: 724-584-5100 x 133

IF SELF-INSURED:
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number: _____

Self-Insured Bureau Code: _____

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

Name of TPA (Claims administrator):

Address:

Telephone Number- _____

myMatrixx
good medicine for business

AmeriHealth Casualty
Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	AmeriHealth CASUALTY
Employee Name:	
Group#:	10602116
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

AmeriHealth Casualty has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

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myMatrixx
PO BOX 274070
Tampa, Fl 33688

AmeriHealth
CASUALTY SERVICES

&

myMatrixx
good medicine for business

Introducing your new Pharmacy Benefit Program for your work related injury

About your pharmacy program:

Your employer has contracted with myMatrixx to have prescriptions for your work related injury filled at no expense to you. Visit any participating pharmacy, present your myMatrixx pharmacy identification card or identify your participation in the myMatrixx pharmacy plan and we do the rest.

Which pharmacies can I use?

You may use any of our participating network pharmacies including CVS, K-Mart, Winn Dixie, The Medicine Shoppe, Publix, and almost any other pharmacy you frequently visit in your community.

What if my pharmacy isn't in the myMatrixx network?

Contact myMatrixx at 877-804-4900 and we will contact your pharmacy and attempt to add them to our network.

What is Covered?

Only medication prescribed by your physician specific to your work related injury. This program does not cover <u>any</u> prescriptions for any other medical condition.

What do I do?

- Take your prescription to the nearest MyMatrixx participating pharmacy. Also bring this letter or your MyMatrixx identification card to confirm your eligibility. For the location of a pharmacy nearest you, please contact our customer service at 877-804-4900 for assistance.
- Present this letter or your card to your pharmacist. This will identify you as a member of your employer's workers compensation prescription plan. Your pharmacist will submit the required information to myMatrixx. You do nothing else.
- In the event there is a problem processing your prescription(s) please call, or have your pharmacist call, the myMatrixx at 877-804-4900.