



RISK ADMINISTRATION SERVICES, INC.

# Employee Injury Report

**IMPORTANT:**

Your claim for benefits cannot be fully processed until your questionnaire is returned.

Last Name	First Name	MI	Birth Date	SSN:	Sex: ___ M ___ F	Marital Status ___ Single ___ Married	# of Children under 21
PO Box/Street Address/City/St/Zip					Phone#:		
Where were you hired?					Length of time employed:		
Date of Injury (mm/dd/yy)			Date you first reported injury:		Name and Title of Person you reported to:		
Time: _____ AM PM (circle one)							
Where were you when injury occurred?		Describe how and what happened to cause this injury:					
Witnesses, Names and Address:							
1. _____							
2. _____							
Note all injuries from this accident: (you must be complete)							
Was your injury the result of someone else's negligence? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes: Name: _____ Address: _____ Phone: _____							
Insurance Co.: _____ Policy or Claim No.: _____							
Name and Addresses of all doctors and hospitals treating you:							
1. _____							
2. _____							
3. _____							
Date of first medical treatment:		Date of most recent treatment:		Are you still under doctor's care?		Are you working?	
___/___/___		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you miss work?	Dates of lost time:	Were you paid for any part of time lost?	<b>TRUCKING QUESTION ONLY:</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Where did your Employer/Company administer your Qualification Tests?				
			(City & State) City _____ State _____				
At the time of your injury, were you employed anywhere else? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes: Name: _____ Address: _____ Duties: _____							
Have you had previous problems or treatments to this body area or areas? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If so, please describe and include the dates you experienced the problems or treatments.							
1. _____							
2. _____							
3. _____							
Have you ever suffered any injuries either work or non-work related before? <input type="checkbox"/> Yes <input type="checkbox"/> No				Have you ever filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so please explain:				When: _____			
				Where: _____			
Name and address of your former employers:					Please list name and address of your group health insurance:		
1. _____							
2. _____							
3. _____							
Name and Address of your family physician:					Are you covered by your spouse's health insurance?		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
Employee Signature:					Date:		

## Instant Access Pharmacy Program

### Employer:

Immediately upon receiving notice of injury, fill in the information to the right and give it to your injured employee.

### Injured Worker:



1. If you need a prescription filled for a work-related injury or illness, go to a Modern Medical participating network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

#### ATTENTION INJURED PARTY:

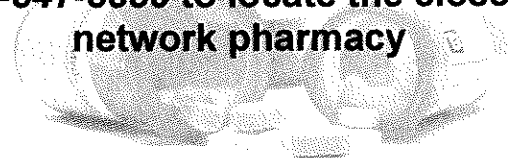
Use of this prescription form is restricted to prescriptions for your allowed condition only. To receive your medication coverage, present this form to a network pharmacy. This is for a one-time prescription fill. If you require additional prescriptions, a permanent card will be mailed to you. For questions, please call Modern Medical at 800-547-3330.

### Pharmacist:

1. Please process this prescription through Catamaran.
2. For questions regarding transmission, rejections or if you encounter any problems processing this prescription, please call Modern Medical's pharmacy department at **800-547-3330**.

<b>Instant Access</b>	
<b>For Your First Prescription Fill</b>	
	
Name:	<u>Center School District</u>
Employer:	_____
RxBIN:	<u>610011</u>
RxPCN:	<u>IRX</u>
Group #:	<u>B31156</u>
Member ID:	_____
<i>(Member ID is month &amp; year of injury and last 4 digits of claimant's Social Security number (i.e. 0720136789))</i>	
	

Use our "Find a Pharmacy" search tool at  
***modernmedical.com*** or call us at  
**800-547-3330** to locate the closest  
**network pharmacy**



## Common chains participating in the pharmacy network:

Access Health	Dillon Pharmacies	Kinney Drugs	Perlmart	The Medicine Shoppe
Acme	Family Care	K-Mart	Pharmacy Express	The Vons Companies
Ahold	Farm Fresh	Kroger	Publix Super Markets	Thrifty White
Albertsons	Food Lion	K-VATT-T Food Stores	Raley's	Tom Thumb Randall's Food & Drug
Albertsons/Sav-On	Foodarama	Leader Drug Stores	Randall's Food & Drug	True Care
Aurora Pharmacy	Supermarkets	Lewis Drugs	Rite Aid	U Save Pharmacy
Bashas	Fred's Pharmacy	Life Check	Ross Park Pharmacy	United Supermarkets
Bi-Lo Pharmacy	Giant Eagle Pharmacies	Long's Drug Stores	RxPride	Unity Pharmacies
Bioscrip	Hannaford Brothers	Major Value	Safeway Pharmacies	Walgreens
Brookshire Brothers	Harris Teeter	Medicap Pharmacies	Save Mart Supermarkets	Wal-Mart
Food &	Hy-Vee	Medicine Chest	Sav-Mor Drug Stores	Wegmens
Pharmacy	Ingles Market	Pharmacies	Shopko Stores	Winn-Dixie Stores
Brookshire's	JH Harvey	Meijer	Smith's Pharmacy	
City Market	Kash N' Karry	Northeast Pharmacy	Spartan Stores	
Costco	Kerr Drug	Services	Super D Drugs	
CVS	King Soopers	Pamida Pharmacy	Supervalu	
		Pavilion Plaza Pharmacy	Target	