

EMPLOYEE INJURY/ILLNESS/FIRST AID FORM

NAME: _____ EMPLOYEE# _____

ADDRESS: _____

PHONE NUMBER: _____

DATE OF INCIDENT: _____ JOB TITLE: _____

BUILDING: _____ AREA IN BUILDING: _____

TIME OF INCIDENT: _____ TIME SHIFT STARTED: _____

DATE & TIME SUPERVISOR NOTIFIED: _____

HOW DID THE INCIDENT OCCUR? _____

PART OF BODY INJURED: _____

NAME OF WITNESS: _____

CIRCLE WHICH ONE APPLIES:

FIRST AID ONLY AT THIS TIME: YES / NO

SEEKED MEDICAL TREATMENT: YES / NO

IF YES WHAT FACILITY: MEDCALL 1-888-735-0036 / WORKING WELL / HOSPITAL

SIGNATURE OF EMPLOYEE: _____ DATE: _____

KEYSCRIPTS

Live-Operator Support
866.446.2848
Email info@keyscriptsllc.com
Visit keyscriptsllc.com
Fax 717.732.9467

Dear Injured Worker:

The attached temporary KeyScripts Prescription Benefit Card will authorize you to obtain prescription medications related to your work injury, with no out-of-pocket expense, **but you must call to activate the card before taking it to the pharmacy.** The call takes only a few minutes. You will be asked for your name, date of birth, employer's name and telephone number, and your date of injury, so please have this information available when you call.

CALL 866.446.2848 TO ACTIVATE YOUR CARD NOW
YOUR ACCOUNT NAME IS: EASTERN ALLIANCE - INDIANA

Write your name and Employee ID number (provided to you during card activation) in the spaces provided on the card. Your card will be immediately activated after your call, and you may then take it to your pharmacy to fill your work injury prescription(s). *NOTE: There may be limitations on how much of your prescription can be filled, based on your employer's prescription benefit plan.*

Do not attempt to fill any prescription other than your work injury prescription using the KeyScripts card. Avoid filling any prescription related to your work injury directly at the prescribing physician's office, as most physicians do not accept prescription benefit cards similar to KeyScripts' for billing purposes.

You may visit your KeyScripts network pharmacy of choice, which includes all of the major retail pharmacies, such as CVS, Rite Aid, Target, Walgreens and Walmart. **Need help finding your nearest network pharmacy? Call KeyScripts at 866.446.2848.**

NOTE: Indiana employs the Official Disability Guidelines (ODG) to assist in the treatment of injured workers. These clinical practice guidelines instruct prescribers to consult the ODG Workers' Compensation Drug Formulary Appendix A published by MCG Health when utilizing pharmacotherapy to treat injured workers. Based on real outcomes from rigorous research, these guidelines are designed to protect the injured worker by recommending the safest, most effective medications available for the respective work injuries.

Your temporary KeyScripts Prescription Benefit Card contains important claims and customer service information for you and your pharmacist. After activation, present the card to your pharmacist when filling any prescription related to your work injury. You will receive a permanent card in the mail shortly.

<p>KEYSCRIPTS For customer service, call 866.446.2848</p> <p>Bin #: 009430 Group ID: EASTIN30 ProCare Rx</p> <p>Employee Name: _____</p> <p>Employee ID: _____</p> <p><i>Workers' Compensation Prescription Benefit Card</i></p>	<p>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.</p> <p>To the Pharmacy: Submit claims via the ProCare System only for the person for whom the prescription was written.</p> <p>ProCare RX 1267 Professional Parkway, Gainesville GA 30507 Pharmacy Help Desk 1.800.277.1657</p>
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INJURY/ ACCIDENT/ INCIDENT INVESTIGATION FORM

Name of Injured Person: _____ Date of Injury: _____

Name of Supervisor: _____ Telephone #: _____

Department: _____ Location of Injury: _____

Brief Description of Injury / Accident:

Nature of Injury (describe all body parts affected):

Was Training Provided?

Yes No NA

Were established procedures followed?

Yes No NA

Were tools or equipment adequate for **task**?

Yes No NA

Were environmental conditions a factor in the incident?

Yes No NA

Elaborate on Responses:

Proposed Corrective Action:

Supervisor: _____ Date of Report _____

Signature: _____

