A.I.M. Mutual
Insurance Companies
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

CONNECTICUT CLAIM KIT

As your new workers' compensation insurance carrier, we ask that you report all accidents to us as soon as possible after they occur. Your prompt notification, together with a complete accident report, will help us to handle your claims fairly and efficiently. This will also help you avoid fines for late reporting.

Here is a supply of the necessary forms along with instructions for their use. You can also find these forms online at www.aimmutual.com. Please feel free to contact us at any time with your questions or service requests.

A.I.M. MUTUAL INSURANCE COMPANIES

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

What to do when an employee has a work-related injury:

- Assess the extent of the injury. Provide first aid if appropriate.
- If the employee requires medical attention, accompany him/her to an approved primary care facility.
- In case of a catastrophic injury, immediately call 911.
- Secure the accident scene.
- Complete the Employers First Report of Injury or Occupational Illness (FRI).
- Fax the FRI to 781-270-5599, report on-line at www.aimmutual.com, or call into the reporting service.
- If the employee will be disabled beyond the date of injury, complete Form 1A-Filing Status and Exemption.
- If the employee is able, have him/her sign the Authorization for Release of Medical Records.

NOTE: If at any time you receive a Form 30 C submitted by one of your employees, it is imperative that you immediately fax it to A.I.M. Mutual and also contact the adjuster assigned to your account.

54 Third Avenue, Burlington, MA 01803-0970

Workers Compensation Claim Reporting Options - Connecticut

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)

Choose from several different ways to report your workers compensation claims to us:

By Fax:

For **Medical Only** claims, complete and fax the First Report of Injury (FRI) form into us at **1-781-270-5599.**

OR

This form must be submitted for injuries that result in incapacity for one day or more. We will notify the state of Connecticut Workers' Compensation Commission in the event a Medical Only claim changes to a lost time.

On-Line, over the Internet *(preferred method)*:

Sign on to www.aimmutual.com and click **"**Report A Claim**".**

Select **To Report A Claim Online** and then click on **Connecticut**. You will be prompted to answer a series of questions similar to the information necessary to complete a First Report of Injury. 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. Click Print for a copy of the information you sent. We will complete and submit the First Report of Injury (FRI) to the state of Connecticut Workers' Compensation Commission. This form must be submitted for injuries that result in incapacity for one day or more. We will notify the state of Connecticut Workers' Compensation Commission in the event a Medical Only claim changes to a lost time.

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. You will receive a completed First Report of Injury (FRI) and a confirmation letter, followed by a claim acknowledgment letter including the name of the Claim Representative assigned to your case. We will submit the FRI to the state of Connecticut Workers' Compensation Commission. We will also notify the state of Connecticut Workers' Compensation Commission when a Medical Only claim has been changed to a lost time claim.

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 Mail:

To facilitate your claim handling, please consider submitting your first report online or by fax or phone. If you need to mail related materials to us, direct it to:
A.I.M. Mutual Insurance Companies, 54 Third Avenue, P.O. Box 4070, Burlington, MA 01803-0970

STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADMINISTERING A CONNECTICUT WORKERS' COMPENSATION CLAIM FOR BENEFITS

PATIENT NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT NAME) (REQUIRED)

BODY PART(S): _____

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

to disclose, in writing, protected health information [PHI] to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Connecticut Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL AND DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT in accordance with state and federal law**.[1] I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law and state law.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization I may, at any time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES. I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCED BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____

Signature of Patient Date

[1] Any consent to release information pertaining to treatment for drug and alcohol abuse must conform to the requirements of state law and the federal regulations, e.g., Part 2 of Title 42 of the Code of Federal Regulations.

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

Workers' Compensation — Employee Medical & Work Status Form

Rev. 9-26-2011

To Be Completed by Attending Physician/Office

Give a copy to employee at time of visit ■ File a copy in medical file
Fax a copy to carrier, TPA, employer, or designee within one business day of visit

Employee Name: _____ Date of Birth: _____ / _____ / _____
(last) (first) (middle)

Employer Name: _____ Department/Division: _____

Employer Address/Location: _____

Initial or *Follow-Up* Visit (circle one) Payer/Managed Care Plan Name: _____ Claim#: _____

Date of Injury/Illness: _____ / _____ / _____ Date of this visit: _____ / _____ / _____ ❑ Employee will be seen in this office for

Employee's job (as stated by employee): _____ follow-up on _____ / _____ / _____ .

WORK STATUS - Having evaluated/treated this employee today, in my opinion:

❑ Employee may continue regular work duty. ❑ There is **no change from prior visit**.

❑ Employee may return to his/her regular work on _____ / _____ / _____ without restriction.

❑ Employee can return to work on _____ / _____ / _____ with the **following functional capabilities**: In an 8-hour workday, employee may:

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Bend/Squat	❑	❑	❑	❑	❑
Climb	❑	❑	❑	❑	❑
Reach	❑	❑	❑	❑	❑
Twist	❑	❑	❑	❑	❑
Crawl	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Foot/Feet	❑	❑	❑	❑	❑
Hand(s)	❑	❑	❑	❑	❑

❑ Patient is able to lift ❑ Patient is **unable to lift greater than** _____ **pounds**.

Patient may use ❑ RIGHT ❑ LEFT ❑ BOTH foot/feet for repetitive movement as in operating foot controls.

Patient may use ❑ RIGHT ❑ LEFT ❑ BOTH hands for repetitive ❑ single grasping ❑ fine manipulation ❑ pushing and pulling.

The restrictions noted above are in effect until _____ / _____ / _____ .

❑ Employee is Temporarily Totally Disabled until _____ / _____ / _____ or pending recheck here on _____ / _____ / _____ .

❑ Employee is on medication that will restrict his/her ability to work safely. Explain: _____

I HAVE DISCUSSED THIS PATIENT'S WORK RESTRICTIONS TELEPHONICALLY TODAY WITH HIS/HER EMPLOYER'S REPRESENTATIVE, OR HAVE COMPLETED THE EMPLOYER'S WORK STATUS FORM IN LIEU OF COMPLETING THE RESTRICTION PORTION OF THIS FORM. RELEASE TO REGULAR DUTY WITHOUT RESTRICTIONS AND/OR TOTAL DISABILITY MUST BE DOCUMENTED USING THIS FORM OR THE EMPLOYER'S STANDARD FORM.

DIAGNOSIS: _____ **TREATMENT PLAN:** _____

Provider Name (print): _____ Provider Address: _____

Provider Signature: _____ Date: _____ / _____ / _____

I have received a copy of this document—Employee Signature: _____ Date: _____ / _____ / _____

54 Third Avenue, P.O. Box 4070 / Burlington, MA 01803-0970 / 800-876-2765 / fax: 781-270-5599

Employer:_____ Date of Injury:_____

Employee: _____ Claim #: _____

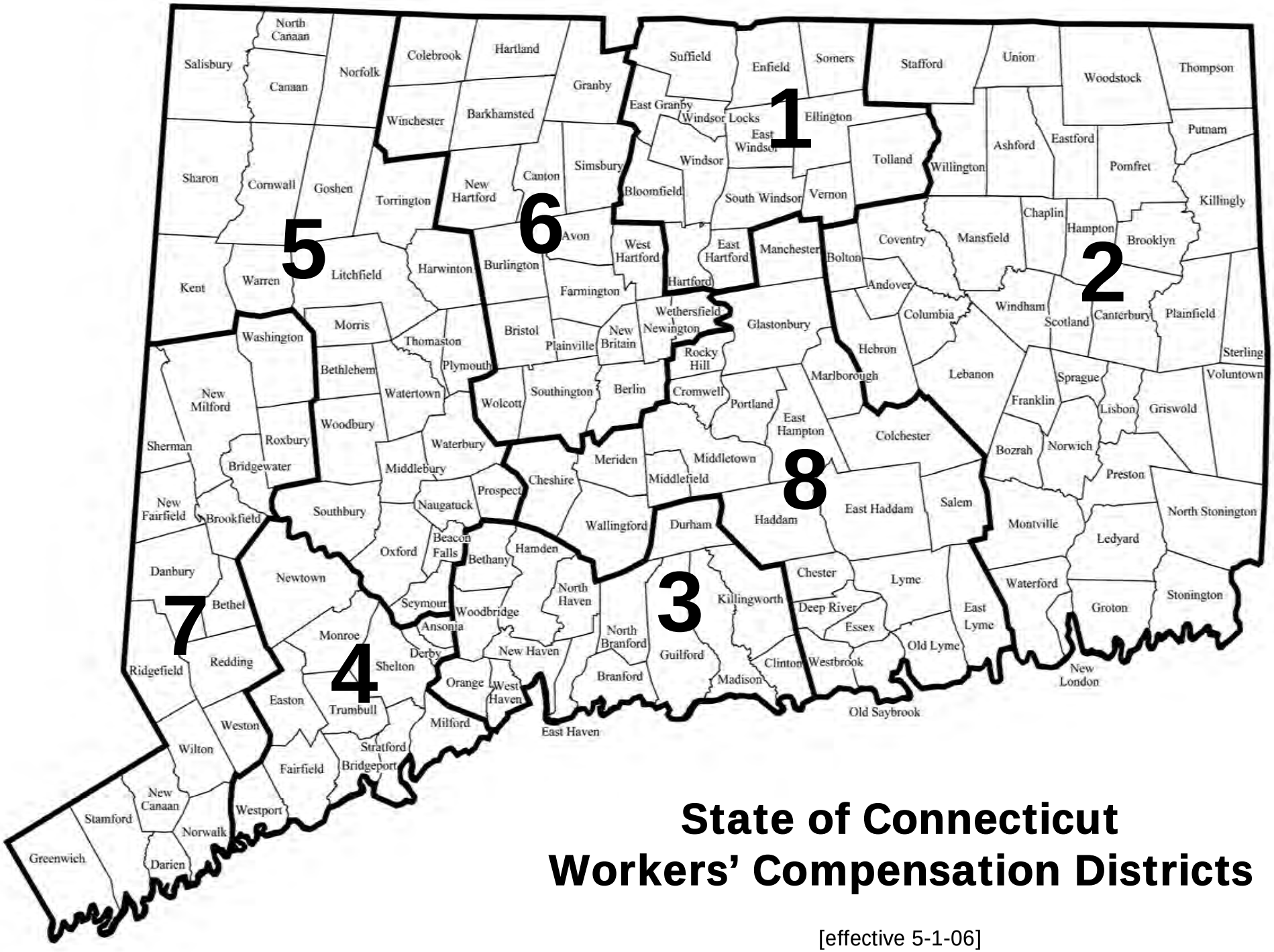
Date of Hire:_____ Hourly Rate:_____

STATE OF CONNECTICUT AVERAGE WEEKLY WAGE SCHEDULE

	Week Ending	Gross Earnings		Week Ending	Gross Earnings
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		

Combined total: _____

Employer/Preparer Signature: _____ Date Signed:_____



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

233 Main Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487

Connecticut MCO Preferred Provider Network
for Policyholders of A.I.M. Mutual Insurance Companies

In the state of Connecticut, A.I.M. Mutual has partnered with CorVel to provide a Managed Care Organization (MCO) for policyholders. In fact, CorVel's MCO is one of the largest in Connecticut, with over 5,000 participating medical providers in its preferred provider network. Through the network, injured workers have access to 28 different medical specialties.

To apply, employers simply fill out an Employer Participation Form or CorVel will complete it on the employer's behalf. A CorVel representative will then be responsible for the state filing.

Frequently Asked Questions

1. **What is a Medical Care Plan?**

   A Medical Care Plan is a managed care approach to work-related illness or injuries, approved by the Connecticut Workers' Compensation Commission. Under this Plan, treatment must be obtained from a provider in the approved Preferred Provider Network in order for the injured employee's benefits not to be in jeopardy.

2. **What is a Preferred Provider Network?**

   Each Managed Care Organization must file a Preferred Provider Network with the state of Connecticut. In order to ensure ample provider coverage for injured workers, each Managed Care Organization must abide by strict standards in order for the state of Connecticut to approve specific specialties to be included in its Preferred Providers Network.

3. **Is there an application fee?**

   No.

4. **What is needed to implement a Medical Care Plan?**

   Per the Connecticut Workers' Compensation Commission, each employer who has twenty-five or more employees per work site, as well as each employer who has twenty-four or fewer employees in Connecticut and whose rate of work related injury and illness exceeds the average incidence rate, shall establish and administer a safety and health committee for that work site. Each committee must have at least 50% labor representation and meet at least quarterly.

5. **What is the process to implement a Medical Care Plan?**

   CorVel submits an Employer Participation form on behalf of the employer to the State of Connecticut's Workers' Compensation Commission for review and approval.

6. How long does it take to receive approval from the State?

The State of Connection has up to 6 months to review and approve an Employer Participation form; however, most approvals are received with 30-90 days from the date of submission.

7. What happens after the State approves an Employer Participation form?

A Welcome package is sent to the employer. The package consists of a copy of the company's Certification of Approval, copies of CorVel's Preferred Provider Network Directory, an announcement of the plan to be posted in a public site easily accessible to all employees and educational materials to be distributed to each employee.

A.I.M. Mutual
Insurance Companies
since 1989

Directory of Participating Medical Providers

For the most complete and up-to-date listing of Medical Providers, please visit the Forms Library on our website at www.aimmutual.com and click on CorVel PPO Look-up.

The site will direct you to participating medical providers throughout Connecticut as well as in nearby states.

CT 100213

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 https://www.express-scripts.com/ and set up an account 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.

A.I.M. MUTUAL INSURANCE COMPANIES

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 VANTAGE

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

_____

AIM Mutual Insurance Companies since 1989

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

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

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®