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

MAINE 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 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

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. 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 or the State of Maine Workers' Compensation Board website: https://www.maine.gov/wcb/forms/index.html

---

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

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. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ 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? ☐ YES ☐ 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: ☐ MALE ☐ 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? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ 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.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	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.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

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.

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): 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. 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? YES ☐ NO ☐
IF YES, GIVE NAME(S):_____
NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.

19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? YES ☐ NO ☐
NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))

20. LIST GROSS EARNINGS FOR EACH WEEK:

WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	WEEK ENDING	GROSS EARNINGS	WK 37	WEEK ENDING	GROSS EARNINGS
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			**WK OF INJURY**		
17			35			**21. TOTAL EARNINGS $**		
18			36			**22. GROSS AVERAGE WEEKLY WAGE $**		

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 ☐ No ☐	Yes ☐ No ☐		$
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Disability Insurance (inc. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐		$
401K	Yes ☐ No ☐	Yes ☐ No ☐		$
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐		$
Pension	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$

19. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	20. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	21. DATE MAILED: ____/____/____ 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: (888) 801-9087 or TTY Maine Relay 711.
WCB-2B (eff. 1/1/13)

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).

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: (888) 801-9087 or TTY Maine Relay 711.

MyMatrixx Pharmacy Program for Injured Workers

As part of our workers' compensation medical management services, we ask injured workers to use a pharmacy program through MyMatrixx. MyMatrixx 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 a MyMatrixx affiliated pharmacy to fill their injury-related prescriptions.

MyMatrixx 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 MyMatrixx 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. MyMatrixx 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 MyMatrixx For a full listing injured workers can go to www.MyMatrixx.com or call MyMatrixx at 1-800-945-5951. While injured employees may use a non-affiliated pharmacy, we strongly recommend they use a pharmacy within the MyMatrixx network and the mail order service to realize the program benefits.

Please call the MyMatrixx Patient Care Contact 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

MyMatrixx
By EVERNORTH

A.I.M. Mutual
Insurance Companies since 1989

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

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

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $999. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number AIMWORKS
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: AIMWORKS

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

© 2025 MyMatrixx Healthcare Services, Inc. |
An Evernorth Company. All Rights Reserved.

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BAKER'S
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
CITY MARKET
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DILLIONS
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD 4 LESS
FOOD LION PHARMACY
FOODS CO
FRED MEYER
FRY'S
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GERBES
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
JAY C FOOD STORE
KINGS SOOPERS
KROGER
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MARIANO'S
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
METRO MARKET
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PAY-LESS SUPER MARKETS
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PICK'N SAVE
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
QFC
RALEY'S
RALPHS
RECEPT PHARMACY LP
RITE AID CORPORATION
RULER
SAFEWAY, INC.
SAM'S CLUB
SMITH'S
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

© 2025 MyMatrixx Healthcare Services, Inc. |
An Evernorth Company. All Rights Reserved.