Key Risk
a Berkley Company

Authorization

The undersigned has filed a claim for workers compensation benefits (hereafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P.O. Box 8000, Daphne, AL 36526-8000.

The undersigned authorizes the release of information and communication between his or her health care provider(s) (including, without limitation, medical laboratories, pharmacies, pharmacy benefit managers, and medical suppliers) and representatives of Key Risk Management Services/Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining to or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related problems.

The undersigned also authorized the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, to release to Key Risk information concerning his or her workers compensation injury, entitlement dates and benefit amounts.

The undersigned further authorizes Key Risk to release any such information to its reinsurers, attorneys, second injury fund consultants, or to medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for the purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ **Date** _____

Employee Name _____ **Employer** _____
(Please Print) **(Please Print)**

Claim Number _____ **Date of Birth** _____

Key Risk
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Letter of Introduction to the Physician

Date: _____

Name of Provider: _____

Street Address or P.O. Box: _____

City, State Zip: _____

Dear Provider:

_____, an employee of, _____, has reported a possible work related injury or illness. We have filed a workers compensation claim with our carrier, Key Risk. Any authorization for treatment or referrals for additional treatment must be directed to Key Risk's claim call center at **866.847.8872**.

Key Risk will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is compensable, all medical bills will be paid directly by Key Risk under our workers compensation policy. Therefore, please forward all medical bills and medical reports **(note: bills cannot be processed without the appropriate supporting medical reports)** directly to:

Key Risk
P.O. Box 8000
Daphne, AL 36526-8000

The injured employee understands that if the claim is found not to be a compensable claim, he or she will be responsible for all bills related to your treatment.

We appreciate your cooperation and assistance. If you have any questions, please contact Key Risk's client service call center at **866.847.8872.**

_____
(Employer)

_____
(Date)

PRINT SAVE AS

Key Risk
a Berkley Company

Physician's Report / Pharmacy Guide

MAILING ADDRESS: P.O. Box 49129, Greensboro, NC 27419
866.847.8872 www.keyrisk.com

EMPLOYER: Please complete the top section and give to the injured employee to take to his or her authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee/Patient: **Last:** _____ **First:** _____

Date of Injury: _____

Name of Employer / Company: _____

Employer Signature: _____ Name of Doctor Chosen: _____

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test **has** been completed ☐ or ☐ **has not** been completed (check one)

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately with no restrictions
☐ May resume work immediately with the following restrictions:

- ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
- ☐ Light work (lifting less than 20 pounds)
- ☐ Medium work (lifting less than 50 pounds)
- ☐ Heavy work (lifting less than 100 pounds)
- ☐ Normal shift
- ☐ Limited hours per day: ☐ 2 hours; ☐ 4 hours; ☐ 6 hours
- ☐ Other: _____

☐ Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right	Both
No Use	☐	☐	☐
Occasional <33% of time	☐	☐	☐
Frequent 34-66% of time	☐	☐	☐
Regular 67-100% of time	☐	☐	☐

☐ Patient may return to work at full duty on (date): _____
☐ Patient has a return appointment on (date): _____ at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature | **Date** | **Physician's Name (type or print)**

Contact Key Risk's Claim Department at 866.847.8872 for authorization for the referral.

PHARMACIST: Process all prescriptions through ***Optum*** for this patient. Contact ***Optum*** at (800) 547-3330 to establish eligibility.

DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION

Walgreens	Leader Drug Stores	King Soopers	Food Lion	Pamida Pharmacy	Medicine Chest Pharmacies
CVS	K-Mart	Medicap Pharmacies	Dillon Pharmacies	Wegmans	Ross Park Pharmacy
Rite Aid	Ahold	Fred's Pharmacy	Life Check	Kinney Drugs	Northeast Pharmacy Services
Wal-Mart	The Medicine Shoppe	Brookshire's	United Supermarkets	Bioscrip	Brookshire Brothers Food & Pharmacy
Giant Eagle Pharmacies	Family Care	Albertsons/Sav-On	Smith's Pharmacy	Spartan Stores	OPTUM® Please call 800.547.3330 for additional participating pharmacies.
Kroger	Long's Drug Stores	Raley's	The Vons Companies	U Save Pharmacy	
Meijer	Bashas	Hannaford Brothers	Sav-Mor Drug Stores	Randall's Food & Drug	
Costco	Harris Teeter	Hy-Vee	Pavilion Plaza Pharmacy	Foodarama Supermarkets	
Publix Super Markets	Kerr Drug	Ingles Markets	Kash N' Karry	Unity Pharmacies	
Albertsons	Winn-Dixie Stores	Aurora Pharmacy	Supervalu	City Market	
Farm Fresh	Major Value	True Care	Perlmart	Thrifty White	
Access Health	RxPride	Save Mart Supermarkets	JH Harvey	Super D Drugs	Tom Thumb Randall's Food & Drug
Target	Safeway Pharmacies	Shopko Stores	Bi-Lo Pharmacy	K-VAT-T Food Stores	Pharmacy Express

First Fill Information

Key Risk

Employer:

Immediately upon receiving notice of injury, fill in the information below 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 an Optum® participating network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

ATTENTION INJURED WORKER

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, call Optum at **1-800-547-3330.**

Pharmacist:

1. Please process this prescription through OptumRx.
2. For questions regarding transmission, rejections or if you encounter any problems processing this prescription, please call Optum at **1-800-547-3330.**

First Fill Form: Complete and take to your pharmacy

RxBin #: **610011** **RxPCN:** **IRX** **Group Number:** **B31412**

Member ID:		Member ID is month and year of injury plus last 4 digits of claimant's SSN number (e.g., MMYYYYSSSS)
Member Name:		Injured worker's first & last name
Employer Name:		Pharmacy Help Desk: **1-800-547-3330**
Date of Injury:		