DATE: _____

FROM: UMB, Environmental Health & Safety, Office of Risk Management

SUBJECT: Reported Work-Related Injury/Illness

Name: _____

Address: _____

City, State, Zip: _____

Phone: Home_____ Work_____

This individual submitted an **Employee's First Report of Injury** notifying the University of Maryland Baltimore that an injury/illness occurred in which they may be entitled to receive workers' compensation benefits. An investigation into the reported injury/illness is in progress to determine compensability.

Please note that a compensability decision is pending. Despite the contrary, please fill the attached prescription(s) to ensure this individual receives preventative medication(s) promptly, as prescribed by the evaluating physician or medical provider. Kindly process related bill(s) for payment electronically to:

Express Scripts 1-800-945-5951

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number **IWIEXP** for needle sticks or human/animal exposures **or** group number **IWI01700** for all other injuries

Step 4: Enter the injured worker's SSN or seven-digit claim number (if available)

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury **(enter in DOI field in the format YYYYMMDD)**

If you have any questions about electronic bill processing, please contact Express Scripts Customer Service at 1-800-945-5951. Please refer all other questions to the Office of Risk Management in Environmental Health & Safety at 410-706-7055.

In rare cases it may be determined an individual is not entitled to receive workers' compensation benefits. In such an instance, the individual is personally responsible for payment of all medications received, subject to any payments made by their private health insurance provider.

In response to the prescription services provided by UMMS pharmacies, the undersigned agrees to be fully responsible for all charges incurred in this matter. **Resultantly, my signature below acknowledges my understanding that I am fully responsible for all charges, including any prescription insurance co-pay(s) or deductible(s) in the event of denial of my claim for workers' compensation benefits.**

Employee Signature_____ Date: _____