FIRST COMP
MARKEL Insuring America's Small Business®

Central Park Plaza North • 222 South 15th Street, Suite 1500N • Omaha, NE 68102-1656
Telephone 888-500-3344 • Underwriting Fax 866-338-2667 • Claims Fax 877-444-6806
Henderson, NV • Cranston, RI • Tampa, FL
www.firstcomp.com

myMatrixx™
good medicine for business

Markel FirstComp

Workers' Compensation Prescription Information

Markel FirstComp:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name: _____

Group#: 10602291 Member ID (SSN):_____

Date of Injury: _____ Claim Number: _____

Processor: myMatrixx Bin#: 014211

Day supply is limited to 5 days for a new injury myMatrixx Help Desk: (877) 804-4900

Employer Signature:_____

Phone: _____ Date:_____

Markel FirstComp:

Markel FirstComp has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. Upon acceptance of your claim a permanent prescription card, specific to your injury, will be forwarded directly to you within 3-5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900.

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HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to redisclosure by the recipients and no longer be protected by federal privacy regulations.

Name _____

Date of Birth _____ Date of Injury _____

SSN _____ Claim # _____

Markel Insurance Services, P.O. Box 3188, Omaha, NE 68103 is authorized to receive and use/redisclose the information in connection with my claim for worker's compensation benefits. I further authorize that a photocopy of this medical release may be used by FirstComp to order and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to: history and physical exam; progress notes: office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to, x-ray, MRI, CT scan, bone scan, thermography reports; thermography films; inpatient admissions and discharge reports; outpatient and emergency room admissions; complete hospital chart; healthcare records in your file from other providers; prescription records; operative reports; physical therapy.

The purpose of use or disclosure of patient information is for my worker's compensation claim. Patient information may be used or disclosed to the parties, their agents and representatives; to the Division of Workers' Compensation; authorized Independent Medical Examiners including the Division of Labor Medical Examiners; Division of Administrative Hearings; vocational experts; entitles involved in a third party action arising out of the Workers' Compensation matter, County and/or District Courts; and any of my past or present health care providers.

I understand that this authorization will expire upon the closure of my worker's compensation claim.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, revocation will not affect any actions the provider took before it received the revocation. Also, I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that I am entitled to receive a copy of this authorization.

Signature of patient
Of patient's representative _____ **Date** _____

Address: _____

If a patient's representative signs this authorization, please complete the following:

Printed name of patient's representative: _____
Relationship to the patient _____

Describe the representative's authority to act for the patient: _____

_____