Key Risk
a Berkley Company

Authorization

The undersigned has filed a claim for workers compensation benefits (hereinafter 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 the 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 14817, Lexington, KY 40512.

The undersigned authorizes the release of information and communication between my health care provider(s) (including without limitation, medical laboratories, pharmacies, 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 or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related medical problems.

To comply with federal law, DO NOT include genetic testing or family medical history records.

The undersigned also authorizes the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and contractors, to release to Key Risk information concerning my workers compensation injury, entitlement dates and benefit amounts for my dependents and me.

The undersigned further authorizes Key Risk to release any such information as described above to its reinsurers, attorneys, second injury fund consultants, 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, and the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for 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: _____

Claim Number: _____ Date of Birth: _____

Key Risk
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Autorización

El abajo firmante ha enviado un reclamo de beneficios de compensación laboral (referido posteriormente como el "reclamo"). La cantidad y tipo de información buscada acorde a esta autorización dependerá de la naturaleza del reclamo, pero será utilizada únicamente para facilitar la determinación en relación a la validez del reclamo y el pago de beneficios o de la administración del programa de seguros bajo el cual el reclamo se ha realizado. Autorizar la revelación de información es voluntario, y la aceptación del reclamo no se condicionará tras haber firmado esta autorización. Esta autorización está sujeta a la revocación en cualquier momento, con la excepción del grado en que cualquier parte haya actuado en confianza al acuerdo. Cualquier revocación deberá enviarse por escrito a Key Risk, P.O. Box 14817, Lexington, KY 40512.

El abajo firmante autoriza la liberación de información y comunicación entre su proveedor médico (incluyendo sin limitación, laboratorios médicos, farmacias, gerentes de beneficios de farmacia y suministros médicos) y representantes de Key Risk Management Services/Berkley Insurance Company ("Key Risk").

Esta liberación de información aplica a todos los registros médicos aplicables, e información de pago de beneficios con respecto a cualquier enfermedad, lesión, historial médico, consulta, prescripción, tratamiento o beneficio y copias de todos los registros aplicables por lo consecuente, lo cual podrá ser apropiado o necesario a través del curso de este reclamo. Esta autorización específicamente incluirá, pero no se limitará a registros médicos, información médica e información de pago de beneficios en relación al tratamiento de SIDA, HIV, enfermedades mentales y problemas relacionados con el abuso de alcohol o drogas.

Para cumplir con leyes federales NO incluya pruebas genéticas o registros de antecedentes médicos familiares.
El abajo firmante también autoriza a la Administración de Seguro Social y los Centros de Medicare y Servicios (CMS, por sus siglas en inglés), sus agentes o contratistas, a liberar información a Key Risk en relación a mi lesión de compensación de trabajadores, fechas de derecho y cantidad de beneficios.
El abajo firmante además autoriza a Key Risk a liberar cualquier porción de dicha información médica a sus aseguradoras, abogados, consultores de fondo de segundas lesiones, o a paneles de revisión médica, CMS, agencias de seguro estatal o de fraude, vendedores de administración de tratamiento, organizaciones industriales contra el fraude o del cumplimiento de la ley, organizaciones de investigación y reporte estatístico al grado que Key Risk considere hacerlo de manera apropiada o necesaria para propósitos de su administración del reclamo o programa de seguro bajo el cual el reclamo se haya realizado.

La información de sus registros revelada a Key Risk cuya confidencialidad es protegida por varias leyes estatales y federales. Cualquier divulgación adicional de esta información no podrá estar sujeta a ciertas protecciones provistas bajo las regulaciones de privacidad federales. A menos que se revoque antes por el abajo firmante, por escrito, esta autorización será válida por tres años después de que Key Risk haya cerrado el reclamo. Una copia de esta autorización será considerada válida como el original.

Firma del empleado: _____ Fecha: _____
Nombre del empleado: _____ Empleador: _____
Número de reclamo: _____ Fecha de nacimiento: _____

Key Risk
a Berkley Company

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 14817
Lexington, KY 40512

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 14817, Lexington, KY 40512
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)**
Facility Name		**Facility Phone Number**

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

PHARMACIST: Process all prescriptions through ***SmithRx*** for this patient. Contact ***SmithRx*** at (844) 414-0701 to establish eligibility. **DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION**

Albertsons	Duane Reade	H-E-B Grogery	Navarro Discount Pharmacy	Shoprite pharmacy
Bartell Drugs	Fairview Pharmacy	Henry Ford Medical Center	Pick N Save Pharmacy	Smith's Pharmacy
Bashas' United Drug	Food City Pharmacy	Homeland Pharmacy	Pillpack	Stop & Shop Pharmacy
Baylor Scott & White Pharmacy	Food Lion	Hy-Vee	Publix Super Market	Target
Bi-Mart Pharmacy	Fred Meyer Pharmacy	Ingles Markets	Quality Food Center	Thrifty Drug Store
Brookshire Pharmacy	Fred's Pharmacy	King Soopers Pharmacy	Ralphs Pharmacy	Tom Thumb Pharmacy
City Market	Fry's Food and Drug	Kinney Drugs	Recept Pharmacy	U Save It
Costco	Giant Eagle Pharmacy	Knight Drugs	Rite-Aid Pharmacy	Vons Pharmacy
Cub Pharmacy	Giant Pharmacy	Kroger	Safeyway Pharmacy	Walgreens
CVS Pharmacy	Hannaford Food and Drug	Maxor Pharmacy	Save Mart	Walmart
Diergerb Pharmacy	Harps Pharmacy	Madicap Pharmacy	Sav-Mor	Wegman Food Market
Dillon Pharmacy	Harveys Supermarket	Medicine Shoppe Pharmacy	Schnuck Market	Winn Dixie

Smi+hRx

Please call 844.414.0701 for additional participating pharmacies.

Key Risk
a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Prescription Benefits Information For Your Workers' Compensation Claim

Welcome to SmithRx.

Your employer's workers compensation carrier has chosen SmithRx to provide pharmacy benefits for their injured workers. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy.

What do I need to do?

If you need a prescription filled for a work-related injury or illness, visit an in-network pharmacy and provide this card to the pharmacist. The pharmacist will fill your prescription at no cost to you.

May I fill prescriptions at my usual pharmacy?

Most pharmacies, including all major chains, are included in this network. To find or inquire about a network pharmacy and whether your preferred pharmacy is included, please call **(844) 414-0701**.

Is this my permanent card?

This card is valid for one-time use. You have 7 days from the date your injury was reported to utilize this card. If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Once you receive it, please use the permanent card going forward.

Your Temporary Pharmacy Benefits Card

Key Risk
a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Employer: _____

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

SmithRx is the designated PBM for this patient

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS: YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx Bin 019025
Rx PCN 8001002
Rx Group KRMFF

Note: Your use of this workers compensation pharmacy benefits card is limited to those prescriptions medically related to a workers compensation injury (covered under applicable state workers compensation regulations).

Questions? Call 844-414-0701

Key Risk
a Berkley Company

Smi+hRx
Pharmacy Benefits. Simplified.

Bienvenido a SmithRx.

Su empleador nos ha elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales. Más adelante incluiremos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia en nuestra red. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Esta tarjeta es válida para un solo uso. Tiene 7 días a partir de la fecha de la lesión para utilizar esta tarjeta.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Puede utilizar esta tarjeta para futuras recetas médicas por lesiones o enfermedades relacionadas con el trabajo.

La mayoría de farmacias, incluyendo todas las grandes cadenas de farmacias, forman parte de nuestra red. Para encontrar una farmacia en nuestra red, llame al **(844) 414-0701**.

¿Tiene Preguntas?

Si tiene alguna pregunta, llame al **(844) 414-0701** (también se encuentra en la parte posterior de su tarjeta de identificación).

Key Risk
a Berkley Company

Smi+hRx
Pharmacy Benefits. Simplified.

Employer: _____

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

SmithRx is the designated PBM for this patient

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS: YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx Bin	019025
Rx PCN	8001002
Rx Group	KRMFF

Nota: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.