PREFERRED EMPLOYERS Insurance
| a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Prescription Benefits Information For Your Workers' Compensation Claim

Welcome to SmithRx.

Your employer 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

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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 PEGFF

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

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Workers' Compensation Injury

Employee Name:_____ Date of Birth: _____Date:_____

PEI Claim Number if Known:_____

Job Title:_____ Employee Phone Number: _____

Company Representative Authorizing (Print Name):_____

Company Name:_____ Policy Number:_____

Company Address:_____ Company Contact E-Mail: _____

Company Phone #:_____ Company Fax #:_____

Attention Provider: This is a Workers' Compensation Claim

Please Send Billing to:
Preferred Employers Insurance Company
PO Box 14817, Lexington, KY 40512
(888) 472-9001

Or via Ebill with Jopari – Preferred Employers Insurance Payor ID is: J1496
For more information regarding Ebill contact Jopari at (800) 630-3060

Send reporting to:
Email: firstreport@peiwc.com

Fax Utilization Review Requests to: (866) 921-7313

Prescriptions

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