EMPLOYER NAME:				
DATE OF INJURY OR ILLNESS MO. DA. YR.	HOUR OF DAY AM. PM.	EMPLOYEE'S TELEPHONE #.	SEX (M OR F)	DATE OF BIRTH MO. DA. YR.

SOCIAL SECURITY NUMBER	NAME (LAST) (FIRST) (M.I.)

HOME ADDRESS	CITY	STATE	ZIP	JOB TITLE

WORK STATUS PART OR FULL TIME	TIME EMPLOYEE BEGAN WORK	DATE OF HIRE	HRS/DAY	DAYS/WEEK	DEPT.	AVG. WEEKLY EARNINGS

EMPLOYEE'S STATEMENT (how and why injury occurred, describe injured body part, objects involved in injury, MVA)

EMPLOYEE SIGNATURE		PLACE OF INJURY	
WAS THIS LOCATION WHERE EMPLOYEE NORMALLY WORKED?			☐ YES ☐
EMPLOYEE JOB DESCRIPTION: Please attach if available.			
IS THIS A REOCCURRENCE OF A PREVIOUS INJURY OR ILLNESS? IF YES, PLEASE GIVE DETAILS: TREATMENT BY WHAT PHYSICIAN			☐ YES NO

EMPLOYEE'S SUPERVISOR		DID SUPERVISOR SEE INJURY HAPPEN?	☐ Y ☐ N
DID ANYONE ELSE SEE INJURY HAPPEN?	☐ Y ☐ N	IF YES, NAME(S)	
DID EMPLOYEE LEAVE WORK DUE TO INJURY FOR TREATMENT?		☐ N	
WAS EMPLOYEE TREATED IN EMERGENCY ROOM?	☐ Y ☐ N	WAS EMPLOYEE IN HOSPITAL OVERNIGHT	☐ Y ☐ N

TREATED BY: NAME	ADDRESS	DATE MO.	DA.	YR

DID EMPLOYEE STOP WORK DUE TO INJURY?	☐ Y ☐ N	DATE OF FIRST FULL DAY OUT	
HAS EMPLOYEE RETURNED TO WORK?	☐ Y ☐	IF YES, ON WHAT DATE?	☐ REGULAR DUTY ☐ LIMITED DUTY
IF LIMITED DUTY, AT LOWER WAGES?	☐ ☐ N	IF YES, AT WHAT AVG. EARNINGS/WEEK?	

HAVE YOU RECEIVED YOUR CLAIMANT INFORMATION PACKET? SIGNATURE _____	☐ Y ☐ N	DATE OF DEATH MO. DA. YR.	
DATE EMPLOYER ADVISED MO. DA. YR. ☐ VERBAL ☐ WRITTEN		**PREPARER'S NAME (PLEASE PRINT)** **TELEPHONE #**	

TODAY'S DATE

BENETECH, INC. P.O. BOX 348, WYNANTSKILL 12198 1-800-698-4753 **CASE NO. FROM LOG _____**

Detach this portion of the form to use as the Pharmacy Benefits Card

****MED FOCUS****
IS THE PREFERRED PROVIDER FOR ALL DIAGNOSTIC TESTING. YOUR DOCTOR MAY CONTACT THEM DIRECTLY TO SET UP YOUR APPOINTMENT BY CALLING: 1-800-398-8999.

Workers' Compensation ID Card

Please submit all Workers' Compensation bills, reports and requests for authorization to:

Benetech, Inc.
P.O. Box 348
Wynantskill, NY 12198
Fax: 518.283.8515
Phone: 1.800.698.4753

This ID Card Only Valid for Work Related Injuries.

Pharmacy ID Card For matrix Workers' Compensation

Employee: Present this card along with your Workers' Compensation prescriptions to your pharmacy.

Pharmacist: Please submit Workers' Compensation claims to Matrix.

BIN: 610208
PCN: NYM
GROUP: BENWC

ID NUMBER: 012910

Pharmacy Call Center 866.352.5171