Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

Temporary Prescription Form

Employers: Please fill out the information below for your injured employee. This form gives the pharmacy authorization to initially fill an injured employee's prescriptions. A representative from the employer must sign this form.

Injured Employee Name: _____**SSN**: _____

DOB: _____ **Phone #:** _____

State Agency: _____ **Date of Injury**: _____

Agency Address: _____

Employer Representative (Print Name): _____

Title:_____

Employer Representative (Signature):_____**Date**:_____

PHARMACY:

This form is authorizing the **INITIAL** fill of the above injured employee's prescriptions with the understanding that additional refills must be authorized by the Workers' Compensation Administrator.

The name, address and telephone number of the Worker's Compensation Administrator is:

PUBLIC EMPLOYEE CLAIMS DIVISION
1200 WEST THIRD STREET
LITTLE ROCK, AR 72201
(501) 371-2700 - Phone
(501) 371-2724 - Fax

Please mail or fax all bills to the above address or fax number.