Temporary Prescription Form

Client Name: Arizona Counties Insurance Pool

1. Instructions for **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary 7 Days, and please fill out the information below:

Injured Worker Name: **SS#:**

Injured Worker DOB: **Injured Worker Phone:**

Injured Worker Address: **Date of Injury:**

City: **State:** **Zip:**

2. Instructions for the **INJURED WORKER**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work-related injury/illness.**

3. Instructions for the **PHARMACY**:

- Please submit claims to **DefinitiRx** using the following information:

BIN	PCN	Group Id	Member Id
610237	AWPRX	ACIP1	Injured Worker SS#

- Prescription(s) will fill for **7 Days.** If there is a remaining balance on the script after the **7 Days** is filled, DefinitiRx will call back if and when the balance has been approved. If you need assistance, please call **DefinitiRx** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332