

# Arkansas Insurance Department

Asa Hutchinson  
Governor



Allen Kerr  
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.

**If electronically submitting the prescriptions, please use the following:**

Stoneriver Pharmacy (Phone Number: (866) 940-4498)  
Bin: 005567  
PCN: TPS  
Date of Injury  
Employer Address

**Walgreens:** please use Comp Today. Comp Today Phone Number: (866) 752-0412

If you would like to paper bill, please fax the bills to:

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