Livingston **EDUCATIONAL SERVICE** Agency

FIRST FILL INFORMATION

NOTE: Please print & provide a copy of this document to the Employee along with a signed Authorization for Treatment.

The Claimant (Employee) should provide the information below to the Pharmacy:

Claimant's Name: **First & Last Name**

PCN: **SCI** Bin # **004410**

Member ID: **CCMSI + last 4 digits of the claimants Social Security Number + MMDDYY** of incident

Group Number: **SEGWC**

Pharmacy Help Desk: **800-661-1494**

EXAMPLE

Claimants Name: **John Doe**

PCN: **SCI** Bin # **004410**

Member ID: **CCMSI1234010214**

MMDDYY of Incident

Last **4 digits** of the claimants Social Security Number

Group Number: **SEGWC**

Pharmacy Help Desk: **800-661-1494**