Pharmacy First Fill Letter of Intent

Pharmacist: Preferred Medical administers this workers' compensation prescription drug program through the ProCare Rx network. For immediate online billing information, contact Preferred Medical at **888-586-4650 Option 1**.

*Please Note: You may be required to send a copy of the Letter of Intent for verification purposes to Preferred Medical via fax 502-489-5045 or email intake@thepreferredmedical.com.

Pharmacy processing steps:

1. Call Preferred Medical at **888-586-4650 Option 1** to obtain the Temporary ID Number.
2. Enter BIN number: **023237**
3. Enter Processor Control Number (PCN): **PMN**
4. Group Number: **MMIAODGF**
5. Enter the **Temporary ID provided by Preferred Medical**
6. Enter Person Code: **01**

Injured Employee: Montana Municipal Interlocal Authority (MMIA) has selected Preferred Medical to administer the prescription drug program for workers' compensation claims. Please present this Letter of Intent to a participating pharmacy for your workers' compensation injury. Preferred Medical provides an extensive network of pharmacies, both large and small and a full list of our network pharmacies are available on our website at www.thepreferredmedical.com. You may also contact Preferred Medical on their toll-free line at 888-586-4650 Option 1 for a list of local participating pharmacies.

This Letter of Intent is to be used for your initial medication fills only. This letter will provide your pharmacist with electronic access to information regarding your eligibility for workers' compensation pharmacy benefits. Use of this Letter of Intent is limited to medications associated with your workers' compensation injury. The payer reserves the right to restrict or suspend the use of your benefits associated with this program at any time.

If your workers' compensation claim is accepted by MMIA, in approximately ten business days you will receive an Rx card from Preferred Medical for future use related to this claim.

Employer Name			
Injured Employee First Name		**Injured Employee Last Name**	
Date of Birth		**Date of Injury**	