

GALLAGHER BASSETT

ARGO GROUP

Gallagher Bassett Claims Program

Argo - OSP - Beacon Mutual is excited to share updates about our Workers' Compensation (WC), Claims Program partnership with Gallagher Bassett (GB).

Claims Handling

Beginning 11/14/26, GB will assume legacy claims handling responsibility for all new and existing Workers' Compensation claims.

GB's goal is to help you resolve claims quickly and fairly, and provide exceptional service and effective communication throughout the claims process.

What you can expect from GB:

Timely, responsive, and empathetic claims professionals to help you navigate your losses

Proactive and responsive service from the time of loss to the resolution of the claim

Any questions or concerns should be directed to:

Argo's dedicated Transition Line
D: 717-458-6163

IF A CLAIM INVOLVES SERIOUS OR LIFE-THREATENING INJURIES

CALL 911

Please contact GB with questions at any time.

Reporting Methods For New Claims:

Web:
expedited.gbgofirstconnect.com/ArgoBeaconMutual

Dedicated QR Code:

Dedicated call in number:
833-820-1674

Dedicated email:
ArgoBeaconMutualClaims@gbtpa.com

When reporting claims, please reference your Client ID: 041990

At Gallagher Bassett, we apply proven strengths in many areas to create a complete risk management program that stands the test of your immediate risk management needs and the test of time.

With a vision focused on results and your constant satisfaction in mind, we offer a value-added approach that never loses sight of our objective—providing a measurable return on your risk management investment.

Learn more about how GB helps deliver superior outcomes at:
GallagherBassett.com

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OBTAINING MEDICAL CARE FOR YOUR INJURED EMPLOYEE:

Through this site you can choose from several options to request the providers. Searches can be done by address, name, region, as well as a quick search which is a preformatted search using a limited number of specialties for providers who provide initial treatment of WC injuries only. Outcome Based Network (OBN) providers are identified by a rainbow circle design before their name. The site also provides you with the capability of creating your own preformatted worksite posters. There is also a selection to look up state rules which gives you a brief description of the state rules that apply to direction of medical care for each state.

GBCARE PHARMACY BENEFIT MANAGEMENT PROGRAM

First Fill Program – this program allows the injured employee to obtain their first fill of medication with no out of pocket expense to the employee. When filling a prescription, injured workers simply present the First Fill information to the pharmacy. Once the pharmacy verifies eligibility, injured employees are enrolled.

With over 68,000 contracted pharmacies, including all major pharmacy chains, our unique program design enables injured workers to receive prescriptions without incurring out of pocket expenses and ensures appropriate medications are dispensed during each stage of recovery. The injured employee can also call 1.844.276-2515 to find participating pharmacies.

To locate in-network providers near your locations at:
goperspecta.com/VPD/gbcare1/

For serious or life-threating injuries,

CALL **911**

or immediately take employee to the nearet emergency room.

BENEFITS OF THE PROGRAM INCLUDE:

No out-of-pocket expense for injured workers

Injured employees can fill their prescriptions on demand (up to 30-day supply of medical) simply by presenting their myMatrixx information to the pharmacy.

Home Delivery Programs

For qualified injured employees, myMatrixx offers home delivery of medications. Depending upon past use and type of injury, the system automatically identifies those who might benefit, providing added convenience and promoting their recovery.

GBGO MOBILE APP

Your injured employee will receive an acknowledgement letter giving them their claim number and resolution manager contact information, along with information on accessing GBGO, our mobile app:





Occupational Injury Temporary Prescription ID Card

GBCARE | myMatrixx by Evernorth

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

myMatrixx, an Express Scripts Company

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: NZEA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

ARGO OSP BEACON MUTUAL

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Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

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Workers Compensation Fax or Email Form

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

To report a claim, please fax this completed form to: 866-668-7780 ***or*** email it to: ArgoBeaconMutualClaims@gbtpa.com

Note: Any question with an asterisk (*) is required information.

Client Information

*GB Client Number	041990
*Client Name	Argo - OSP - Beacon Mutual

Date and Time of Accident

*Incident Date	Enter date.	Incident Time	Enter time.
*Employer Notified Date	Enter date.		

Client Location

Location Code	Enter Location Code.				
*Client Name	Enter Client Name.				
Street Address	Enter Street Address.				
City	Enter City.	*State	Choose State.	ZIP	Enter ZIP.
Phone Number	Enter phone #.				

Submitter/Preparer Information

Name	Enter Name.
Title	Enter Title.
Phone Number	Enter Phone #.
Email Address	Enter Email.

Claimant Information

*Social Security Number	Enter SSN.				
*First Name	Enter First Name.			Middle Initial	Enter Initial.
*Last Name	Enter Last Name.				
Home Phone	Enter Phone #.			Work Phone	Enter Phone #.
Street Address	Enter Street Address.				
City	Enter City.	State	Choose State.	ZIP	Enter ZIP.
Email Address	Enter Email.			Cell Phone	Enter Phone #.
Date of Birth	Enter date.	Marital Status			Choose...
Gender	Choose...				

Workers Compensation Fax or Email Form

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Employment

Occupation	Enter text.
Employment Status	Enter text.
*Date Hired	Enter date.

Wages

Amount	Enter amount.
Frequency	Enter frequency (hourly, salary, etc.)

Incident Information

*Detailed Description of Incident	Enter Description.		
Part and side of Body	Enter Part and side of Body.		
Injury Type	Enter Injury Type.		
Cause of Injury	Enter Cause of Injury.		
Date Last Worked	Enter date.	Date Returned to Work	Enter date.
Date of Death (if applicable)	Enter date.		

Medical Provider *(Only if medical treatment rendered)*

Hospital/Clinic Name	Enter text.				
Street Address	Enter Street Address.				
City	Enter City.	State	Choose State.	ZIP	Enter ZIP.
Phone Number	Enter Phone #.				
Doctor Name	Enter Name.				
Street Address	Enter Street Address.				
City	Enter City.	State	Choose State.	ZIP	Enter ZIP.
Phone Number	Enter Phone #.				

GB Questions

*Policy Number: *Was outside medical treatment provided for the injured worker?	Enter text.
*Will the injured worker lose time from work other than the day of injury?	Enter text.

Workers Compensation Fax or Email Form

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*For which state are payroll taxes withheld for the employee?	Choose State.

Accident Location *(Enter SAME, if same as reporting location)*

Location Name	Enter Location Name.				
Street Address	Enter Street Address.				
City	Enter City.	*State	Choose State.	ZIP	Enter ZIP.
Client Premises?	Choose...				

Contact Information

*First and Last Name	Enter Name.
*Phone	Enter Phone #.

Additional Dissemination Information

Who should receive an email confirmation for this loss?	Enter text.
Email Address	Enter Email.

Notes/Additional Comments *(ie, if there were witnesses or if this is for report only)*

Additional Remarks	Enter text.

NOTE: Please advise if this was a vehicle accident, should an Auto Loss be entered from this loss information?	Choose...