

EMPLOYER: Give both pages of this document to the injured employee to provide to the authorized treating physician.

Employer/Company: [REDACTED]

EMPLOYEE: The following provider/facility was selected from CorVel's provider network. It is your responsibility to contact the provider to schedule an appointment and to confirm the location.

Employee name: [REDACTED]

Record ID: [REDACTED]

Date of injury: [REDACTED]

Treating physician/facility:

INITIAL TREATMENT PROVIDER/FACILITY:

Provider/Facility Name

Address

Call to schedule an appointment

Provider Location

Appointment Details

Date: _____

Time: _____

PHARMACY: Process all prescriptions online through CorVel's pharmacy program for this patient and DO NOT charge the patient for the prescription. Call CorVel at (800) 563-8438 (8am – 11pm, M-F) for additional assistance. The Member ID is 9 digit social security number plus 8 digit date of injury.

PARTICIPATING PHARMACIES*

- | | | |
|------------------------|-------------------------------|-----------------------------|
| CostCo Pharmacy | Hy-Vee Inc | Smith's Food & Drug Centers |
| CVS | Kroger Pharmacy | Stop & Shop Supermarket Co |
| Dominick's Finer Foods | Medicine Shoppe International | Target Pharmacy |
| Fred's Inc | Meijer Pharmacies | Walgreens Pharmacy |
| Giant Eagle Pharmacy | Publix Pharmacies | Wal-Mart Pharmacy |
| Giant Food Stores LLC | Rite Aid Pharmacy | Winn-Dixie Pharmacies |
| H E Butt Drug Stores | Shoprite Supermarkets Inc | |

*This is only a partial list of the over 70,000 participating pharmacies in the CorVel Network. Please call (800) 563-8438 for additional locations.

CVS CAREMARK | **CORVEL**[®]

**Temporary Pharmacy Card
(First Fill Only)**

Bin: 004336
PCN: ADV
RX Group: RXFF
Member ID: SSN + Date of Injury
ex: 12345678901012011

EMPLOYEE: Take this form with you and have the treating physician complete the Physician section below.

Employee name: _____

Record ID: _____

Date of injury: _____

Physician/facility: _____

PHYSICIAN: For compliance, please complete this section and email to RTW@onlinecapturecenter.com or fax to (800) 391-4320. This document authorizes initial evaluation and treatment only, and payment for these services will be rendered without prejudice.

DIAGNOSIS: _____

A post-accident drug test (check one): **has been completed** **has not been completed**

RESTRICTIONS:

In accordance with this patient's physical capability, check all that apply:

- May resume work immediately, no restrictions.
- May resume work immediately, with the following restrictions:
 - Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
 - Light work (lifting less than 20 pounds) Medium work (lifting less than 50 pounds)
 - Limited hours: _____ hours per day Limited days: _____ days per week
 - Other: _____
 - Repetitive motion restrictions (specific to hand/arm injuries):

FREQUENCY	No Use	Occasional	Frequent	Constant
LEFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient is unable to return to work in any capacity.

RETURN TO WORK/MMI/NEXT APPOINTMENT:

Date patient may return to work at full duty: _____ / _____ / _____

Projected date of attainment of Maximum Medical Improvement: _____ / _____ / _____

Patient has a return appointment on (date): _____ / _____ / _____ at (time): _____ AM / PM

ANCILLARY SERVICES:

Please call (866) 866-1101 if patient requires Physical Therapy, Imaging, DME, Transportation or Translation services.

Physician Name: _____ Date: _____

Physician Signature: _____