Initial Treatment Guide | Physician and Pharmacy Information

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

CORVEL

Physician's Report

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

Employee name: [redacted] **Record ID:** [redacted]

Date of injury: [redacted] 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	☐	☐	☐	☐
RIGHT	☐	☐	☐	☐

- ☐ 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:_____