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

Employer/Company:

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

Employee name: 

Date of injury: 

Record ID: 

INITIAL TREATMENT PROVIDER/FACILITY:

Provider/Facility Name 

Address 

Call to schedule an appointment 

Provider Location

Appointment Details 

Date: 

Time: 

Disclaimer: The provider/facility listed above is provided for informational purposes only and is not intended to require the employee to seek medical treatment with the provider/facility listed. The rights of the employee in choosing a provider/facility vary by state and each state law and/or statute supersede any information implicitly or explicitly stated on this guide.

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 

Cvs 

Dominick’s Finer Foods 

Fred’s Inc 

Giant Eagle Pharmacy 

Giant Food Stores LLC 

H E Butt Drug Stores 

Hy-Vee Inc 

Kroger Pharmacy 

Medicine Shoppe International 

Meijer Pharmacies 

Publix Pharmacies 

Rite Aid Pharmacy 

Shoprite Supermarkets Inc 

Smith’s Food & Drug Centers 

Stop & Shop Supermarket Co 

Target Pharmacy 

Walgreens Pharmacy 

Wal-Mart Pharmacy 

Winn-Dixie Pharmacies 

*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.

Temporary Pharmacy Card 
(First Fill Only)

Bin: 004336 

PCN: ADV 

RX Group: RXFFWC300 

Member ID: SSN + Date of Injury 

ex: 12345678901012011

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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):

<table>
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<th>Frequent</th>
<th>Constant</th>
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</table>

□ 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: ____________________________________________

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