CORVEL

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: _____ STATE OF NC- ADMIN. OFFICE OF THE COURTS

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: **Record ID:**

Date of injury: Treating physician/facility:

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 state by state and each state law and/or statute supersedes any information implicitly or explicitly stated on this guide.

PHARMACY: Process all injury-related prescriptions through CorVel's pharmacy program. Use of this program will waive any co=pay or cost to the claimant. Call CorVel at (800) 563-8438 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	Shoprite Supermarkets Inc.
CVS Pharmacy	Kroger Pharmacy	Smith's Food & Drug Centers
Duane Reade Pharmacy	Medicine Shoppe International	Stop & Shop Supermarket Co
Fred's Pharmacy	Meijer Pharmacies	Target Pharmacy
Giant Eagle Pharmacy	Publix Pharmacies	Walgreens Pharmacy
Giant Food Stores LLC	Rite Aid Pharmacy	Wal-Mart Pharmacy
Harris Teeter Pharmacy	Safeway Pharmacy	Winn-Dixie Pharmacies

*This is only a partial list of the over 65,000 participating pharmacies in the CorVel Network. Please call (800) 563-8438 for additional location.

CVS CAREMARK CORVEL

First Fill Only

Bin:	004336
PCN:	ADV
RX Group:	RXFFWC9525768
Member ID:	SSN + Date of Injury

(ex: 123456789**01012011**)

CORVEL

Physician's Report

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	☐	☐	☐	☐
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

Physician Name: _____Date:_____

Physician Signature: _____