



# 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:

**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.

**Medical Billing Address:**

PO Box 6966  
Portland, OR 97228  
Fax: 888-851-9190

**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.




**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](mailto: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):

<b><u>FREQUENCY:</u></b>	<b>No Use</b>	<b>Occasional</b>	<b>Frequent</b>	<b>Constant</b>
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): \_\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_