NC STATE UNIVERSITY

GM-CHNC-State_of_NC_Claims@corvel.com
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Phone: 704-941-2800 or 1-800-365-5998 Fax: 800-272-5779

Supervisor's Medical Treatment Authorization | Medical Provider's Report | First Fill Prescription Drug

Deliver completed both: **HR Benefits/University Leave Administration WorkersComp@ncsu.edu Phone 919.515.2151 Fax 888.317.2890 report to Environmental Health & Safety AccidentReport@ncsu.edu Phone 919.515.7915 Fax 919.515.6307**

Supervisor: Please complete Section A and give to the injured employee to take with them to the authorized treating medical provider. This form authorizes their initial care. The remainder of the form is to be completed by the medical provider and should be **delivered to HR Benefits/University Claim Service and Environmental Health & Safety within 24 hours** from the notice of the alleged injury/disease.

Section A: Patient Information	
Employee First/Last Name:	Today's Date:
Employee ID No.:	Employee Phone:
Supervisor/Manager Name:	Supervisor/Manager Phone:
Supervisor's Signature:	Date of Injury: ___ / ___ / _____ Time of Injury: ___ / ___ / ☐ AM ☐ PM

Authorized Treatment Facilities: **Supervisor**, for injuries in Wake County, please direct your employee to one of these facilities:

- ☐ Wake Medical Urgent Care, 601 Oberlin Drive, Raleigh NC, 27605, 919-789-4322
- ☐ Next Care Urgent Care, 1110 Kildare Farm Road, Cary, NC 919-481-0277

FOR INJURIES OUTSIDE OF WAKE COUNTY, DIRECT EMPLOYEE TO THE NEAREST URGENT CARE CENTER –

Information: Hospital Emergency Rooms should only be used for extreme injuries and for after-hours treatment that cannot wait.

Authorized Treatment Facilities: Supervisor/Manager please direct your employee to a local network provider based on location.

For a complete list of network providers & pharmacies, visit Provider Lookup | Login (caremc.com)

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.**

Section B: Diagnosis, Treatment, and Medication Information

Diagnosis(es) for treated body parts:

Treatment Provided:	**List medication(s)/prescription(s)/sample(s) given (include dose):**

Section C: Work Status Information

- ☐ Patient may **return to work without restrictions** on ___ / ___ / _____ (date). **Skip to Section E.**
- ☐ Patient may **return to work with restriction(s) shown in Section D. on** ___ / ___ / _____ (date)
- ☐ Patient may **not return to work as of** ___ / ___ / _____ (date) until a follow-up appointment, described in Section E.

Section D: Work Restrictions Information

Posture Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs allowed per day	a/t	Max hrs allowed per day	a/t
Standing _____	☐	Squatting/Kneeling _____	☐
Sitting _____	☐	Stooping/Bending _____	☐
Twisting _____	☐		

Other:

Movement Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs allowed per day	a/t	Max hrs allowed per day	a/t
Walking _____	☐	Grasping/Squeezing _____	☐
Climbing _____	☐	Wrist Flex/Extension _____	☐
Reaching _____	☐	Overhead Reaching _____	☐

Other:

Above Restrictions apply to:
☐ Neck ☐ Back(upper) ☐ Back(lower) ☐ L Hand ☐ L Wrist ☐ L Arm ☐ L Shoulder ☐ R Hand ☐ R Wrist ☐ R Arm ☐ R Shoulder
☐ L Foot ☐ L Ankle ☐ L Knee ☐ L Leg ☐ R Foot ☐ R Ankle ☐ R Knee ☐ R Leg
Other:

Lift or Carry Restrictions (if any) ☐ **NO Restrictions** ☐ May not lift or carry objects more than ___ lbs for more than ___ hrs/day
☐ No lifting or carrying Other:

Push or Pull Restrictions (if any) ☐ **NO Restrictions** ☐ May not pull or push objects more than ___ lbs for more than ___ hrs/day
☐ No pushing or pulling Other:

Additional Restrictions:

Section E: Follow up appointments

☐ Patient has **return appointment on** ___ / ___ / _____ (date) at ___:___ ☐ AM ☐ PM

Medical Provider – You must contact University Claim Service at 919-515-2151 for referral authorization.

Medical Provider's Signature Date Medical Provider's Name (print)

See P2 of this form for pharmacy information.

Pharmacy Instructions
Process all injury-related prescriptions through CorVel's pharmacy program. The use of this program will waive any co=pay or cost to the claimant. For assistance with claims processing, please contact the CorVel Pharmacy Department,
(800) 563-8438.

Please use the **BIN, PCN, and RxGroup** number below to process an online/electronic claim to CorVel
The **Member ID** is 9 digit social security number plus 8-digit date of injury (**XXXXXXXXXMMDDYYYY)**.

First Fill Only

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

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.