

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: ____ / ____ / <input type="checkbox"/> AM <input type="checkbox"/> 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

Concentra Raleigh Center 4909 Green Road, Raleigh NC 27616 (919)790-0288

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):
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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) <input type="checkbox"/> NO restrictions (a/t=as tolerated) Max hrs allowed per day a/t Standing _____ <input type="checkbox"/> Sitting _____ <input type="checkbox"/> Twisting _____ <input type="checkbox"/> Other: _____		Movement Restrictions (if any) <input type="checkbox"/> NO restrictions (a/t=as tolerated) Max hrs allowed per day a/t Squatting/Kneeling _____ <input type="checkbox"/> Stooping/Bending _____ <input type="checkbox"/> Other: _____	
Max hrs allowed per day a/t Walking _____ <input type="checkbox"/> Climbing _____ <input type="checkbox"/> Reaching _____ <input type="checkbox"/> Other: _____		Max hrs allowed per day a/t Grasping/Squeezing _____ <input type="checkbox"/> Wrist Flex/Extension _____ <input type="checkbox"/> Overhead Reaching _____ <input type="checkbox"/> 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 (**XXXXXXXXMMDDYYYY**).

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.