



Please provide all requested information. Incomplete/illegible forms will be returned for additional information. EHIM, Powered by ProCare Rx, is providing coverage of medications used to treat patient's **work-related injury**.

A. Patient Information						
Patient Name:		Date of Birth:		Cardholder ID:		
Group #:	PA#:	Claim #:				
B. Prescriber Information						
Prescriber Name:		NPI #:	Phone #:		Fax#	
C. Medication Information						
Medication:		Quantity:		Day S	Day Supply:	
This medication is NOT related to th information is required.)	e treatment of a worl	k-related injury. (If applical	ble, please sigi	n and date bo	ttom of form, no additional	
New therapy						
Continuation of therapy (If yes, provide	de therapy start date:	/				
Directions for use:						
Duration of treatment:						
D. Clinical Information						
Diagnosis:						
Describe the use of this medication in relation	on to the treatment of	the nationt's work-related in	iury:			
Describe the use of this medication in relation	on to the treatment of	the patient's work-related in	juiy.			
List any other medications with dates of trea	tment that have been	n used to treat this condition:				
		ny supporting documentat	ion, labs, or te	est results.		
Additional comments or information importar	nt to this request:					
Prescriber's Signature:				Date:		
If you have any ques	stions or uraent reauc	ests, please contact the Wor	kers' Compens	ation Departm	nent	
, 52 5, qua		4-6411 or fax (248) 204-639				

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www.ehimrx.com