ProCare Rx

WORKERS' COMPENSATION
Request for Medical Necessity

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 Supply:

☐ This medication is NOT related to the treatment of a work-related injury. *(If applicable, please sign and date bottom of form, no additional information is required.)*

☐ New therapy

☐ Continuation of therapy *(If yes, provide therapy start date: ____/____/____)*
mm dd yy

Directions for use:

Duration of treatment:

D. Clinical Information

Diagnosis:

Describe the use of this medication in relation to the treatment of the patient's work-related injury:

List any other medications with dates of treatment that have been used to treat this condition:

Please ensure that you attach any supporting documentation, labs, or test results.

Additional comments or information important to this request:

Prescriber's Signature:	Date:

If you have any questions or urgent requests, please contact the Workers' Compensation Department at (248) 204-6411 or fax (248) 204-6390.

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