EHIM
Pharmacy Benefits. *Managed.*

WORKERS' COMPENSATION
Request for Medical Necessity

Patient Information		**Prescriber Information**
Patient Name:		Prescriber Name:
Birth Date:	Cardholder ID:	NPI:
Group #:	PA #:	Phone:
Claim #:		Fax:

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:

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

Clinical Information

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

Diagnosis:

Please list any other medications (including dates of treatment) that have been used to treat this condition:

Please attach any supporting documentation, labs, or test results. Thank you for your prompt attention to this matter.

Additional Comments or information important to this request:

Doctor'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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