



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:
<input type="checkbox"/> This medication is NOT related to the treatment of a work-related injury . <i>If applicable, please sign and date bottom of form. No additional information is required.</i>			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy <i>If yes, provide therapy start date: ___ / ___ / ___ (mm/dd/yy)</i>			
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 <u>work-related injury</u>.			
Clinical Information			
Describe the use of this medication in relation to the treatment of the patient's <u>work-related injury</u> :			
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.			

EHIM, Inc.

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