What to do if you experience an on the job injury or illness

If you become injured or sick on the job, we want to help you get well and get back to work. A work-related injury or illness can upset your life. You may be confused about how and where to get the attention you need to get back on your feet. To help you through this difficult time, your employer has formed a team to assist you in your recovery. The team includes:

• Your employer's workers' compensation representative - a person you can turn to for advice on how to get started.

• Hunter Consulting - known for its understanding of work-related injuries and illnesses and its rapid response to injured employees' needs.

  Hunter Consulting Company
  Attn: Penny Lammers
  6600 Clough Pike, FL 2
  Cincinnati, OH 45244
  Phone (513) 372-8703
  Email: plammers@hunterconsulting.com

• An experienced provider network -physicians, therapists, and other health professionals specially qualified to treat your work-related injury or illnesses.

Hunter Consulting is ready to help you, the most important member of the team, get well so you can get back to work. We will stand by you throughout the entire workers' compensation process, helping make sure you have access to the quality care you deserve. When you become sick or injured on the job, Hunter Consulting is ready to assist you in getting the care you need.

Follow these five steps to help ensure you get the treatment and benefits due you.

1. Report the Injury Immediately

Unless it is a life-threatening emergency, report your injury, accident, or illness to your supervisor or Kenyon College representative before you leave work. Failure to report an injury may cause delay in getting benefits due to you.

2. Get your Forms - Injury Reporting Kit

This packet contains your necessary forms, which include an Initial Report Form, First Report of Injury and a Medical Release. Complete the forms with your supervisor or Kenyon Representative. He or she will need these in order to report your injury.

3. Seek Medical Treatment

Your visit to the provider should take place as soon as possible after your injury. At your visit, have the treating physician complete the Physician’s Report of Work Ability form and sign the First Report of Injury form. We ask that you seek medical attention from the Medical Group listed below. You may seek treatment from any provider; however, the provider must be BW certified.

<table>
<thead>
<tr>
<th>Name:</th>
<th>(Non-Emergency)</th>
<th>Name:</th>
<th>(Emergency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Mid- Ohio Corporate Care</td>
<td>Address:</td>
<td>Knox Community Hospital</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>1490 Coshocton Road</td>
<td>City, State, Zip:</td>
<td>1330 Coshocton Road</td>
</tr>
<tr>
<td>Phone:</td>
<td>(740) 393-9675</td>
<td>Phone:</td>
<td>(740) 393-9000</td>
</tr>
<tr>
<td>Hours:</td>
<td>M - F 7:00 am – 5:00 pm</td>
<td>Hours:</td>
<td>24 Hours</td>
</tr>
</tbody>
</table>

4. Return your Forms to your Supervisor and your Workers’ Compensation Representative in Human Resources

Return all completed forms and medical documentation to your supervisor and your workers’ compensation representative in Human Resources immediately.

5. Let Your Employer Know

After each appointment, let your Kenyon College representative know that you have seen your medical provider. In addition, Hunter Consulting will assist to manage your care, help arrange your return to work, and keep your employer updated on your condition.
INITIAL REPORT OF WORK-RELATED INJURY or ILLNESS

1. Employee Name __________________________

2. Date of Birth (mo./day/yr.) __________/

3. Soc. Sec. # __________ - ________ - ________

4. ☐ Female ☐ Male

5. Home Address (# and street, city, state, zip) ____________________________________

6. Home Phone _______ - _______ - _______

7. Department ____________________________

8. Date Hired (mo./day/yr.) __________ /

9. Job Title ______________________________

10. Date of injury or illness (mo./day/yr.) ______/_____/_____

11. Time of injury or illness _____________ am ☐ pm

12. Name(s) and Phone(s) of Witness(es) __________________________________________

or ☐ No Witnesses

13. Name of Supervisor Notified ______________________ Date & Time Notified ____________

14. Did employee receive medical treatment following this incident? ☐ Yes ☐ No

If yes: Medical Provider (name, phone, address) ______________________________________

Date ____________ Was employee treated in an emergency room? ☐ Yes ☐ No Was employee hospitalized overnight? ☐ Yes ☐ No

15. Describe what caused the injury/symptoms, where you were and what you were doing just before the incident, and what you did immediately following the incident.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

16. What part(s) of your body were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger)

________________________________________________________________________________________

17. What type of injury did you experience? (BE SPECIFIC: for example, strain, scrape, bruise, laceration)

________________________________________________________________________________________

18. Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, last treatment for previous injury: __________

19. Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: ________________________________

Medical Release

Under current workers’ compensation law, the employer is entitled to a signed medical release.

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my employer’s managed care organization, or to my employer’s designated representative, Hunter Consulting Company. A copy of this form will serve as the original.

____________________________________________________

Employee’s Signature Date

I have reviewed this report and acknowledge its receipt.

____________________________________________________

Supervisor’s Signature Date
First Report of an Injury, Occupational Disease or Death

By signing this form, I:
• Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers’ compensation laws;
• Waive and release my right to receive compensation and benefits under the workers’ compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
• Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
• Confirm that I have not received compensation and/or benefits under the workers’ compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

By filing this claim, I:
• Confirm that I have not received compensation and/or benefits under the workers’ compensation laws of another state for this claim, in injury or occupational disease for which I am filing this claim;
• Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease, for which I am filing this claim;
• Waive and release my right to receive compensation and benefits under the workers’ compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

Injured worker and injury/disease/death info.

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Social Security number</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home mailing address</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>9-digit ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wage rate</th>
<th>What days of the week do you usually work?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat</td>
</tr>
<tr>
<td></td>
<td>☐ Other ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers’ Compensation?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please explain.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer name</th>
<th>Mailing address (number and street, city or town, state, ZIP code and county)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Location, different from mailing address                                                                       |                                                                 |
|                                                                                                             |                                                                               |

<table>
<thead>
<tr>
<th>Was the place of accident or exposure on employer’s premises?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no, give accident location, street address, city, state and ZIP code</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of injury/disease</th>
<th>Time of injury</th>
<th>If fatal, give date of death</th>
<th>Time employee began work</th>
<th>Date last worked</th>
<th>Date returned to work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of accident</th>
<th>Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer policy number</th>
<th>Check ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone number</th>
<th>Fax number</th>
<th>E-mail address</th>
<th>Federal ID number</th>
<th>Manual number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(         )</td>
<td>(         )</td>
<td>(         )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was employee treated in an emergency room?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was employee hospitalized overnight as an inpatient?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification - The employer certifies that the facts in this application are correct and valid.</th>
<th>Rejection - The employer rejects the validity of this claim for the reason(s) listed below:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For self-insuring employers only

<table>
<thead>
<tr>
<th>Certification - The employer certifies that the facts in this application are correct and valid.</th>
<th>Rejection - The employer rejects the validity of this claim for the reason(s) listed below:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer signature and title

<table>
<thead>
<tr>
<th>Date</th>
<th>OSHA case number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BWC-1101 (Rev. 6/12/2014)
FRIO-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)
This form provides important information about the injured worker’s ability to work.

- The treating physician must submit this form each time he/she sees the injured worker unless the injured worker has been awarded permanent and total disability, has returned to work without restrictions within seven days of the injury, or is being treated after the treating physician has released him/her to his/her former position without restrictions.
- Please complete this form and provide a copy to the injured worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the injured worker’s employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the injured worker’s current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the injured worker.

Instructions

MEDCO-14 submission section: You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

Employment/occupation section: Please indicate if you have reviewed a description of the injured worker’s job held on the date of the injury. Please indicate all sources providing you a description of the injured worker’s job. If you do not have a copy of the injured worker’s job description, BWC or the MCO can help secure one.

Work status/Injured worker’s capabilities section: Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the injured worker’s work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

3A: Please indicate if the injured worker has any physical or health restrictions related only to the allowed conditions in the claim. If there are restrictions, please indicate if the restrictions are permanent or temporary. If there are no related restrictions you should check the release to work box. The date of the exam will be the release to work date.

3B: If there are restrictions related only to the allowed conditions in the claim, indicate whether or not the injured worker can return to the full duties of his/her job held on the date of injury. If you determine the injured worker cannot return to the full duties of his/her job held on the date of the injury, you must included the date for which you indicate the injured worker could not fully perform the duties of his/her job held on the date of the injury. You must also indicate an estimated date when you believe the injured worker should be able to fully perform the duties of the job held on the date of injury. It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker’s claim. Updates to dates in 3B requires 4A to be completed.

3C: Although an injured worker may not be able to fully return to the job held on the date of injury, understanding the injured worker’s capabilities will assist in identifying appropriate and safe work that an injured worker may be able to perform. If an injured worker may return to available and appropriate work with restrictions accommodated, please indicate the possible return to work date. Further, to facilitate BWC’s efforts to safely return an injured worker to appropriate work, indicate which of the activities listed in this section, the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Please note that if the “yes” box is checked in response to the question of whether the injured worker has functional restrictions based only on allowed psychological conditions the MEDCO-16 should be referenced as needed.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker’s safety and care relative to any return to work considerations.
### Instructions for Completing the Physician's Report of Work Ability

**Instructions continued**

<table>
<thead>
<tr>
<th>4A: Disability period information section: It is critical that if you answered No to 3B or made changes to dates in 3B this section is fully completed: Please furnish the narrative description of the diagnosis(es), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate by checking the appropriate box whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4B: In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.</td>
</tr>
</tbody>
</table>

| Clinical findings section: Provide medical rationale for the delay in the injured worker’s recovery and the barriers to return to work. |

| Maximum medical improvement (MMI) section: Provide the MMI date or explain why the injured worker has not reached MMI. Provide the proposed treatment plan, including estimated duration. |

| Vocational rehabilitation section: If the injured worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the injured worker return to employment. |

| Treating physician’s signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible. |

<table>
<thead>
<tr>
<th><strong>For more information or assistance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please contact your local BWC customer service office, or call 1-800-644-6292. You can obtain BWC forms at <a href="http://www.bwc.ohio.gov">www.bwc.ohio.gov</a>, at all BWC customer service offices, or by calling 1-800-644-6292 and listening to the options to reach a BWC customer service representative.</td>
</tr>
</tbody>
</table>
### Injured worker name

<table>
<thead>
<tr>
<th>Date of injury</th>
<th>Date of last appointment/examination</th>
<th>Date of this appointment/examination</th>
<th>Date of next appointment/examination</th>
</tr>
</thead>
</table>

#### MEDCO-14 submission (Select one of the options below.)

1. [ ] I have never completed a MEDCO-14. **Proceed to section 2.**
2. [ ] I have previously completed a MEDCO-14, and all of the information remains the same. **Proceed to and complete section 8.**
3. [ ] I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

#### Employment/Occupation (Complete this section and proceed to section 3.)

2. Have you reviewed the description of the injured worker’s job held on the date of injury (former position of employment)? Yes [ ] No [ ]

3. **Work status/Injured worker’s capabilities** *(Updates Yes [ ] No [ ])*

   - Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes [ ] No [ ]
   - If yes, are the restrictions:  
     - Permanent [ ] Temporary [ ] **Proceed to section 3B.**
   - If no, please check the box to indicate the injured worker is released to work as of the date of this exam. [ ] Proceed to section 8.

#### Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)

If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date:

The injured worker can perform simple grasping with:
- Left hand [ ] Right hand [ ] Both [ ]

The injured worker can perform repetitive wrist motion with:
- Left hand [ ] Right hand [ ] Both [ ]

The injured worker’s dominant hand is:
- Left [ ] Right [ ]

If the injured worker can perform repetitive actions to operate foot controls or motor vehicles with:
- Left foot [ ] Right foot [ ] Both [ ]

*Operate heavy machinery: Yes [ ] No [ ] *Drive: Yes [ ] No [ ] *Perform other critical job tasks as defined by any source listed above in section 2: Yes [ ] No [ ]

#### Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

<table>
<thead>
<tr>
<th>Activity</th>
<th>Lifting/carrying</th>
<th>Pushing/pulling</th>
<th>Activity</th>
<th>Lifting/carrying</th>
<th>Pushing/pulling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N O F C</td>
<td>N O F C</td>
<td></td>
<td>N O F C</td>
<td>N O F C</td>
</tr>
<tr>
<td>Bend</td>
<td></td>
<td></td>
<td>Reach above shoulder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squat/kneel</td>
<td>Type/keyboard</td>
<td></td>
<td>Work with cold substances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twist/turn</td>
<td>Work with hot substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### How many total hours can the injured worker work:
- _____ per week
- _____ per day

In an eight-hour workday, how many total hours can the injured worker:
- Sit: _____ hours
- Walk: _____ hours
- Stand: _____ hours

Does the injured worker have any functional restrictions based only on allowed psychological conditions? Yes [ ] No [ ]

Additionally, in this space, please provide any additional information addressing the injured worker’s capabilities and/or job accommodations which may not be addressed above.

---

**BWC-3914 (Rev. Aug. 21, 2015)**

**Proceed to section 4.**
Injured worker name | Claim number | Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) | (Updates Yes ☐ No ☐)

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

<table>
<thead>
<tr>
<th>Narrative description of the work-related allowed condition</th>
<th>Site/location if applicable</th>
<th>ICD code</th>
<th>Is the condition preventing full duty release to the job injured worker held on the date of injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. | (Updates Yes ☐ No ☐)

The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected

Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker’s delay in recovery.

Maximum medical improvement (MMI) | (Updates Yes ☐ No ☐)

MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐

If yes, give MMI date: _______________. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation | (Updates Yes ☐ No ☐)

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker’s restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?

Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician’s name (please print legibly) | Address, city, state, nine-digit ZIP code

Treating physician’s signature

BWC provider (Peach) number | Date | Telephone number | Fax number

BWC-3914 (Rev. Aug. 21, 2015)

MEDCO-14
Policy # 20005746
Kenyon College is a Self Insured employer represented by Hunter Consulting Company.

Please send all medical reports and billings to:
Hunter Consulting Company
6600 Clough Pike, 2nd FL
Cincinnati, Ohio 45244

All inquiries should be directed to Hunter Consulting at
(513) 372-8703 or plammers@hunterconsulting.com
Hunter Consulting Company
Workers’ Compensation
PriorityRx Prescription Payment Authorization Form

*Please keep this Authorization Form on file with script for auditing purposes.*

Pharmacist:
This is a temporary workers’ comp Rx payment authorization form.
Please contact the M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637) prior to submitting prescription(s). If you have any questions or experience any issues, please contact M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637).

Processing information
Processor: EHO (Employer Health Options)
Bin #’s: 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Eckerd’s/Rite Aid Condor Code = 2185
(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: ________________________________
First Name: ________________________________
Group#: 81207    Sex: Male [   ]   Female [  ]
Employer: ________________________________
ID#/ SS#: ________________________________
D.O.B.: _____ / ____ / ______

Prior Authorization #: ______________________ (retain this # for future use)
Prior authorization # = DOI in YYMMDD format (Example: July 20, 2014 would be 140720)

Date Sent: ________________________________

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