CCMSI

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Phone: 888-596-8771 Fax: 217-477-6631

State of North Carolina Workers' Compensation Program
Supervisor's Initial Medical Treatment Authorization | Medical Provider's Report

Supervisor: Please complete Section A and give to injured employee to take with them to the authorized treating medical provider. **This form authorizes their initial care.** The remainder of the form is to be completed by the medical provider and should be returned to the employee's supervisor or agency workers' compensation administrator within 24 hours after treatment.

Section A: Patient Information	
Employing Agency/University:	Today's Date:
Employee First/Last Name:	Employee Phone:
Supervisor/Manager Name:	Supervisor/Manager Phone:
Date of Injury:___/___/___ Time of Injury:___:____ am pm	Location of Injury (if known):
Initial Treating Provider/Facility Name, Address, Phone Number:	

Authorized Treatment Facilities: Supervisor/Manager please direct your employee to a local network provider based on location. For a complete list of network providers, visit https://www.talispoint.com/login/. Username: strata Password: SONC99
Hospital Emergency Rooms should only be used for extreme injuries or after-hours treatment that cannot wait.

Treating Medical Provider: PLEASE COMPLETE SECTIONS B through E.

Section B: Diagnosis, Treatment, and Medication Information

Diagnosis(es) for treated body parts:

Treatment Provided:	**List medication(s)/prescription(s)/sample(s) given (include dose):**

Section C: Work Status Information

☐ Patient may **return to work without restrictions** on ___/___/___ (date). **Skip to Section E.**
☐ Patient may **return to work with restriction(s) shown in Section D. on ___/___/___ (date)**
☐ Patient may **not return to work as of ___/___/___ (date)** until a follow-up appointment described in Section E.

Section D: Work Restrictions Information

Posture Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs. allowed per day	a/t	Max hrs allowed per day	a/t
Standing_____	☐	Squatting/Kneeling_____	☐
Sitting _____	☐	Stooping/Bending _____	☐
Twisting _____	☐		

Other:

Movement Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs allowed per day	a/t	Max hrs allowed per day	a/t
Walking _____	☐	Grasping/squeezing _____	☐
Climbing _____	☐	Wrist Flex/Extension _____	☐
Reaching _____	☐	Overhead Reaching _____	☐

Other:

Above Restrictions apply to: ☐ L Hand ☐ L Wrist ☐ L Arm ☐ L Shoulder ☐ R Hand ☐ R Wrist ☐ R Arm ☐ R Shoulder
☐ Neck ☐ Back (upper) ☐ Back (lower) ☐ L Foot ☐ L Ankle ☐ L Knee ☐ L Leg ☐ R Foot ☐ R Ankle ☐ R Knee ☐ R Leg
Other:

Lift or Carry Restrictions (if any) ☐ **NO Restrictions** ☐ May not lift or carry objects more than _____ lbs for more than _____ hours/day
☐ No lifting or carrying Other:

Push or Pull Restrictions (if any) ☐ **NO Restrictions** ☐ May not push or pull objects more than _____ lbs for more than _____ hours/day
☐ No pushing or pulling Other:

Additional Restrictions:

Section E: Follow up appointments

☐ Patient has **return appointment on** ___/___/___(date) at ___:____ ☐ AM ☐ PM

Medical Provider – You must contact CCMSI at 888-596-8771 for referral authorization.

_____ _____ _____
Medical Provider's Signature **Date** **Medical Provider's Name (print)**

See separate "State of North Carolina First Fill Prescription Card Form" for first prescription drug fill details and participating pharmacies.

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® Comp MC Rx

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CCMSI
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	COCMSNCFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

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PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM® Comp MC Rx

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CCMSI
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	COCMSNCFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

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