29112

REQUEST FOR PRIOR AUTHORIZATION OF MEDICATION

MEDCO-31

(TO BE COMPLETED ONLY BY PRESCRIBING PHYSICIAN)

INJURED WORKER INFORMATION

Request Date / /

BWC Claim Number:

Injured Worker Name:

Injured Worker SSN: - -

Injured Worker Date of Injury: / /

PRESCRIBER INFORMATION

Prescriber:

Prescriber Phone: - -

Prescriber Fax: - -

Physician Street Address

City

State

Zip Code -

MEDICATION REQUESTED AND CONDITIONS BEING TREATED (REQUIRED)

Medication Name	ICD-9 Code(s)	ICD-9 Code Description(s)
1.		
2.		
3.		
4.		

ADDITIONAL INFORMATION

Requested Duration of Authorization:

JUSTIFICATION FOR REQUEST: (**REQUIRED** - Attach separate sheet if needed)

Please document how the medication(s) requested is/are related to the treatment of, or the control of symptoms associated with the allowed conditions in the claim.

Prescriber Signature (**REQUIRED**):

Signature Date / /

Please fax completed form to: **866-213-6066**

TO SPEAK TO AN ACS CUSTOMER SERVICE REPRESENTATIVE, PLEASE CALL:
1-800-OHIOBWC

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