

Medical Authorization and Attending Physician's Report

EMPLOYER, PLEASE COMPLETE Press firmly to go through 4 copies.

Name of Employee/Patient: Last		First	
Date of Injury:		Social Security Number:	
Name of Employer/Company:			
Employer Signature:		Doctor to be Seen:	

Employer: Prior to using this form for an injured employee, briefly identify activity that would meet possible work restrictions. Work with your Claims Representative or Loss Control Specialist.

Sedentary	Light	Medium	Heavy

Authorized Physician, Please Complete

_____ has been treated today for _____

A post accident drug test (check one) has has not been completed.

In accordance with this patient's physical capability, check all that apply:

- May resume work immediately, no restrictions
- May resume work immediately with the following restrictions:
- Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
- Light work (lifting less than 20 lbs.)
- Medium work (lifting less than 50 lbs.)
- Heavy work (lifting less than 100 lbs.)
- He/she is released to work:
 - _____ hours per day
 - His/her normal shift

- Repetitive Motion Restrictions

Frequency	Left _____	Right _____
Occasional <33% of time		
Frequent 34-66% of time		
Constant 67-100% of time		

- He/she may return to work at full duty on (date) _____
- He/she has a return appointment on (date) _____ at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature _____ Date _____ Physician's Name (type or print) _____

Be sure to contact the NCLM-RMS claims department to gain authorization for the referral. Contact NCLM Worker's Compensation Dept. for referral, authorization, pre-certification, or if billing questions arise.

PHARMACIST:

Please process all Workers' Compensation Claims for this patient through Cypress Care Inc. The Member Number is the SSN listed above. The Group Number is **IC1006**. The Cypress Care BIN# is **010876**. If you have any questions or problems please contact Cypress Care at 1-800-419-7191.
Do not charge this patient for the prescription.

DISTRIBUTION INSTRUCTIONS:

This form must be returned to the employer the same day of treatment. Distribute copies as follows:

Green: Employer **Canary:** Physician **Pink:** Patient **Goldenrod:** Pharmacy