

Date: [Date]

TO: [Pharmacy Name / Pharmacy Benefit Manager]

ATTN: Workers' Compensation Department

FAX: [Pharmacy Fax Number]

RE: Initial Evaluation Prescription Authorization

Claimant Name: [Injured Worker Name]

Date of Injury: [Date of Injury]

Claim Number: [Claim Number]

Social Security Number (Last 4): [Last 4 Digits]

Employer: [Employer Name]

To Whom It May Concern,

This letter serves as formal authorization for the initial evaluation and fills of prescriptions related to the workers' compensation injury sustained by the above-named claimant.

Please process the following prescriptions under the workers' compensation claim:

- [Medication Name/Dosage]
- [Medication Name/Dosage]

Billing Instructions:

Please bill the insurance carrier or Third Party Administrator (TPA) directly at the address below. Do not seek payment from the patient.

[Insurance Carrier Name]

[Billing Address]

[City, State, Zip Code]

[Adjuster Name and Phone Number]

If there are any issues processing this authorization or if the claim is under further review, please contact our office immediately at [Your Phone Number].

Sincerely,

[Authorized Signature]

[Printed Name and Title]

[Clinic/Facility Name]