

**Date:** [Date]

**To:** [Pharmacist Name/Pharmacy Name]

**From:** [Employer Name/Insurance Carrier Name]

# EMERGENCY MEDICATION AUTHORIZATION

**RE: Workers' Compensation Claim**

**Injured Worker Name:** [Employee Full Name]

**Date of Injury:** [Date of Incident]

**Claim Number:** [Claim Number]

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

To the Pharmacist: Please dispense a **[Number, e.g., 7 or 14] day supply** of emergency medication for the injured worker named above. This individual has sustained a work-related injury and this letter serves as a temporary authorization for initial prescriptions related to the injury.

## **Billing Instructions:**

Please do not bill the patient. Submit the bill for this prescription to the Pharmacy Benefit Manager (PBM) listed below:

- **PBM Name:** [PBM Name, e.g., Optum, Express Scripts]
- **BIN:** [BIN Number]
- **PCN:** [PCN Number]
- **Group ID:** [Group ID]
- **Processor Help Desk Phone:** [Phone Number]

If the claim cannot be processed electronically, please contact the adjuster at **[Adjuster Phone Number]** or mail the bill to:

[Insurance Company/TPA Name]

[Mailing Address]

[City, State, Zip Code]

**Authorized Signature:** \_\_\_\_\_

**Title:** [Title of Representative]