CORVEL

Letter of Medical Necessity

Please return completed form(s) to CorVel - Fax: (877) 701-6396; E-mail: pharmacy@corvel.com

Claimant/Claim Information:

Claimant Name: _____ **Claim Number:** _____

Member ID: **Claimant DOB:**

Prescriber Information:

Prescriber Name: _____ **Prescriber ID:** _____

Prescriber Phone: **Prescriber Fax:**

Please verify and/or add phone number if incorrect or not found.

Medication: **Approximate Cost:**

1. Is the medication prescribed to treat the claimant's injury related claim of ?

   ☐ **Yes** ☐ **No**

   (If NO, please sign and date form; no further responses are required. **If YES, please provide a detailed explanation:**)

   _____

   _____

   _____

   _____

   _____

   _____

2. Diagnosis for which the medication is being prescribed: _____

   (Please provide diagnosis code if applicable)

3. Please select one of the below:

   ☐ **New Therapy** ☐ **Renewal (Date therapy first initiated: _____)**

Anticipated length of use:

☐ One Time Fill
☐ 1-3 Months
☐ 4-6 Months
☐ Greater than 6 Months

List other medications that have been used to treat this condition, including dates of therapy:

Medication Name:	Date:
1. _____	_____
2. _____	_____
3. _____	_____

Signed,

_____ _____

[signature of prescribing physician] [date]