

Business Insurers of Georgia

AUTHORIZATION FOR MEDICAL TREATMENT FOR WORKERS' COMPENSATION

PROVIDER: Sunz / Next Level Administrators
Policy: Business Insurers of Georgia #WC014-00001-021

COMPANY NAME: _____

EMPLOYEE NAME: _____

DATE OF INJURY: _____

TYPE OF INJURY: _____

PERFORM A DRUG SCREENING: YES / NO (CIRCLE ONE)

PERFORM A BLOOD ALCOHOL SCREENING: YES / NO (CIRCLE ONE)

BILL TO: Genex: Next Level Administrators, LLC
PO Box 6811
Scranton, PA 18505
Fax: 1-833-223-9672

OR E-MAIL: nextlevelgenex@edmgroupp.com


SIGNATURE OF SUPERVISOR

DATE

Workers' Compensation First Fill Program

EMPLOYER:

Please fill out the employee information below and provide this document to the injured worker to take to any pharmacy for authorized prescriptions.

Mitchell ScriptAdvisor		
Temporary Prescription Benefit Card		SCRIPT CARE, LTD.
Member ID:		
Date of Injury + Date of Birth Example: MMDDYYMMDDYY		
Rx BIN:		004410
PCN:		SCI
Group:		IPS001077TC



Employee

- Present this sheet to the pharmacist along with your prescription.
- Provide your Date of Injury and Date of Birth at the pharmacy to use as your Member ID#.
- This document serves as a temporary prescription card. You may also receive a permanent prescription card specific to your injury, which will be forwarded directly to you within the next 3-5 business days.
- This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.



Pharmacy

- This sheet is a Temporary Prescription ID Card for a **14 Days'** Supply Fill and maximum amount of **\$150.00**.
- All information necessary to process this request is included on the card represented above. **For questions or rejections, please call (866) 846-9279.** Please do not send patient home or have patient pay for medication(s) before calling Mitchell ScriptAdvisor for assistance.