



## Temporary Prescription Form

Client Name: [Minnesota Counties Intergovernmental Trust](#)

### 1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary **7 Days**, and please fill out the information below:

**Injured Worker Name:**

**SS#:**

**Injured Worker DOB:**

**Injured Worker Phone:**

**Injured Worker Employer:**

**Date of Injury:**

**Injured Worker Address:**

**City:**

**State:**

**Zip:**

### 2. Instructions for the **INJURED WORKER**:

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

### 3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **AWPRx** using the following information:

| <b>BIN</b> | <b>PCN</b> | <b>Group Id</b> | <b>Member Id</b>   |
|------------|------------|-----------------|--------------------|
| 610237     | AWPRX      | MCITI           | Injured Worker SS# |

- Prescription(s) will fill for a **7 Days**. If there is a remaining balance on the script after the **7 Days** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332**

*The Right Med. At The Right Time. At The Right Price.*