Coventry
TCM REFERRAL FORM

☐ RUSH REFERRAL

TCM Referrals
Email: tcm_coventry@Aetna.com
Phone: 877-559-8601
Fax: 800-366-5899

ACCOUNT SALES MANAGER INFORMATION

First Name | Last Name
Phone | Cell | Email

REFERRAL INFORMATION

Coventry Referral # (internal use only) | Date of Referral
Referral Source (Name) | Referral Source (Company Name)
Referral Source Address
City | State | Zip
Phone | Fax | Email
Billing Address (if different from address above)
City | State | Zip
Name of Adjuster if different from Referral Source | Phone

CLAIMANT INFORMATION

First Name | Last Name
SSN | Date of Birth | Gender: M ☐ F ☐
Address
City | State | Zip | Phone

CLAIM INFORMATION

Claim Number | Date of Injury | Claim Juris
Affected Body Part
Program Name | Diagnosis

EMPLOYER INFORMATION

Employer | Contact Name
Client Job Title | Average Weekly Wage | Weekly Indemnity
Address
City | State | Zip | Phone

PHYSICIAN/PROVIDER INFORMATION

Name
Address
City | State
Zip | Phone

ATTORNEY INFORMATION

Name
Address
City | State
Zip | Phone

SUBMIT RESET

SPECIAL INSTRUCTIONS

Approval to use DMEplus? ☐ Yes ☐ No

Case Type Please choose | Referral Type Please choose

All RxRN referrals require the following unless customer utilizes First Script as their PBM:

- Any drug utilization reviews/assessments completed by your PBM in the previous 12 months
- 2 years of pharmacy history
- Any drug testing results completed in previous 6 months