

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employee's Name _____

Address _____

City _____ State _____ Zip _____

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Home Telephone _____ Work Telephone _____

XXX-XX- ☐ M ☐ F / /

Last 4 Digits of SSN Sex Date of Birth

Employer's Name _____ Telephone Number _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Carrier _____

Carrier's Address _____ City _____ State _____ Zip _____

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Carrier's Telephone Number _____ Fax Number _____

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
				TOTAL	\$

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature_____
Carrier's approval**Reimburse employee**Yes ☐ no ☐**Reimburse drug store**Yes ☐ no ☐**EMPLOYEE: Mail your bill in duplicate promptly to employer and/or insurance carrier**

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.