

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

IC File # _____
 Emp. Code # _____
 Carrier Code # _____
 Employer FEIN _____

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

Employee's Name _____			Employer's Name _____			Telephone Number _____							
Address _____			Employer's Address _____			City _____	State _____	Zip _____					
City _____			State _____			Zip _____							
Home Telephone _____			Work Telephone _____			Insurance Carrier _____			Policy Number _____				
Social Security Number _____			<input type="checkbox"/> M <input type="checkbox"/> F	Sex	Date of Birth _____			Carrier's Address _____			City _____	State _____	Zip _____
						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.