

IC FILE # _____

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

Emp. Code # _____

Carrier Code # _____

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

Employer FEIN _____

Employee's Name _____

Employer's Name _____ Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

() _____ () _____
Home Telephone _____ Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

M F / /
Social Security Number _____ Sex _____ Date of Birth _____

() _____ () _____
Carrier's Telephone Number _____ Fax Number _____

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
TOTAL					\$ 0.00

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

Reimburse employee
Yes No

Reimburse drug store
Yes No

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.

Employee signature

Carrier's approval

Employee: Mail your bill in duplicate promptly to employer and/or insurance carrier