

**ITEMIZED STATEMENT OF CHARGES FOR DRUGS**

IC File # \_\_\_\_\_

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 \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex  M  F Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Carrier's Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
<b>TOTAL</b>					<b>\$</b>

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.**