

NO STAPLES IN
BAR CODE AREA



Dept. of Labor and Industries
PO Box 44268
Olympia WA 98504-4268

STATEMENT FOR PHARMACY SERVICES

DO NOT
WRITE IN
SPACE >

Helpful Information on the reverse side.

Worker's soc. sec. no. (for i.d. only)		Claim no.
Worker's name (last, first, middle) print or type		
Worker's mailing address		
City	State	ZIP
Pharmacy billing date	Employer	

Pharmacy name & address	L&I Provider no.
	NCPDP No.

Is this a request to reimburse the injured worker? YES NO

Amount
Paid By
Injured
Worker \$

Do not complete this form for reimbursement of a private insurance co-payment. Call L&I at 1-800-848-0811 for instructions.

Prescription (RX) Information

Print Or Type All Information

DX Code (ICD-9)	S/B	Date of injury	Date Rx written	Prescribing Physician's name		Physician's L&I #
Prescription #	Date Rx filled	Est. days supply	Quantity (units)	Refill YES <input type="checkbox"/> NO <input type="checkbox"/>	Generic Rx Substitution allowed? YES <input type="checkbox"/> NO <input type="checkbox"/>	
National Drug Code	Drug name			DUR codes		
Remarks						Total prescription cost \$

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Reimburse the injured worker: Pharmacist must sign and attach prescription receipts for payment.

The injured worker has paid for the above services and prescription(s).

Pharmacist's Signature

X

When you submit this bill, you are certifying that the prescription information is correct.

L&I must receive this statement within 12 months of the date of service or claim allowance.

