STATEMENT OF CHARGES FOR DRUGS AND MEDICAL SUPPLIES

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
Division of Workers' Compensation
1312 Executive Center Drive, East
Tallahassee, FL 32301
Phone: 1-800-342-1741

INSTRUCTIONS: Pharmacist or other provider - Complete this form in detail. If purchase is charged, mail the form directly to the Insurance Carrier or self-insured Employer. If cash purchase, give form to worker. Worker should sign REQUEST FOR REIMBURSEMENT below and send the form to the Insurance Carrier or self-insured Employer.

Employer's Firm Name and Mailing Address	Injured Employee's Name	Employee's Social Security No.
	Bill To:	Date of Accident
		C/M File No. (if known)

1	Prescription No.	Medication and Strength		Quantity	Days Supply	Selling Price
	Date Dispensed	New ____ Refill ____	Name of Prescribing Physician			Cash ____ Charge ____
2	Prescription No.	Medication and Strength		Quantity	Days Supply	Selling Price
	Date Dispensed	New ____ Refill ____	Name of Prescribing Physician			Cash ____ Charge ____
3	Prescription No.	Medication and Strength		Quantity	Days Supply	Selling Price
	Date Dispensed	New ____ Refill ____	Name of Prescribing Physician			Cash ____ Charge ____

OTHER MEDICAL SUPPLIES FURNISHED AND NAME OF PRESCRIBING PHYSICIAN

4	Description	Prescribing Physician	Purchase Date	Cash ____ Charge ____	Selling Price
5	Description	Prescribing Physician	Purchase Date	Cash ____ Charge ____	Selling Price

[redacted] TOTAL CHARGES THIS STATEMENT

NAME AND ADDRESS OF PHARMACY OR OTHER PROVIDER	DATE OF THIS STATEMENT
	SIGNATURE OF PHARMACIST OR OTHER PROVIDER

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

REQUEST FOR REIMBURSEMENT
I have expended cash amounts as shown above and hereby request reimbursement.

Date: _____ **Signature of Employee** _____