WORKERS' COMPENSATION REQUEST FOR PRESCRIPTION DRUG REIMBURSEMENT

DATE:	
NAME:	DATE OF INJURY:
SOCIAL SECURITY NUMBER: _	
The following prescription drug(s) are	re being submitted for reimbursement (attach pharmacy receipt):
(A	TTACH RECEIPTS HERE)
·	
Please reimburse employ	yee Please reimburse provider
	is accurate, that all medications for which I am requesting my workers' compensation claim, and that I have not been any of the amounts claimed.
Signature:	Date: