

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

IC File # _____

Emp. Code # **0004210**

Carrier Code # **999-000**

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN _____

Employee's Name _____

NC DOT
Employer's Name _____ Telephone Number _____

Address _____
City _____ State _____ Zip _____

Employer's Address _____ City _____ State _____ Zip _____
SELF-INSURED

Home Telephone _____ Work Telephone _____

Insurance Carrier
NCDOT WORKERS' COMP
1594 MAIL SERVICE CENTER
RALEIGH, NC 27699-1594

XXX-XX- _____

Carrier's Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex _____ Date of Birth _____

(919) 250-4200 _____ **(919) 212-3121**

Carrier's Telephone Number _____ Fax Number _____

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

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

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

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.

