Mail completed forms to:
Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Statement For Pharmacy Services

- We do not reimburse for private insurance co-payments.
- Read the instructions on the back before you start. Please print clearly.
- When you submit this bill, you are certifying that the prescription information is correct.
- We must receive this statement within 12 months of the date of service or claim allowance.

Injured Worker Reimbursement:
Receipts are required for injured worker reimbursement. Did you attach your receipts? ☐ Yes ☐ No

Worker and Pharmacy Information:

		Worker's SSN (for ID only)	Claim number
Pharmacy name & physical address		Worker's name (Last, First, Middle Initial)	
		Worker's mailing address	
		City State Zip Code	
Pharmacy L&I provider number or NPI	DEA number	Pharmacy billing date	Employer name

Prescription Information:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code		Drug name			Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:				Prescription clarification code	Total Prescription Cost:

Injured Worker Signature:
These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Injured Worker name (please print) ____________________ Injured Worker's signature ____________________

Complete each section.

Injured Worker Reimbursement:

Did you attach your receipts?	Check the appropriate box for attaching receipt. Receipts are required for injured worker reimbursements. Send copies of the receipts only. Be sure to write your claim number on each receipt.

Worker Information:

Worker's social security number	Worker's social security number. Used to verify claim number.
Claim number	Claim number prescription should be billed to.
Worker's name	Worker's legal name in the last, first, middle initial format.
Worker's mailing address	Worker's mailing address (can be a PO Box).
Employer's name	Worker's employer at the time of injury.

Pharmacy Information:

Pharmacy name & address	Pharmacy name and physical location.
Pharmacy L&I provider number or NPI	Pharmacy's L&I provider number or L&I registered NPI.
NCPDC number	National Council for Prescription Drug Programs number.
Pharmacy billing date	Date prescription was filled.

Prescription Information:

Date Rx written	Date prescription was written.
Prescribing provider name	Prescribing provider's name.
Prescribing provider number	Give one of the following numbers for the prescription provider: L&I provider number; NPI; Washington state license number; or DEA number.
Prescription number	Prescription number.
Date filled	Date prescription filled.
Refill number	If the prescription is a refill, enter refill number (0-99). If original prescription, enter "0".
Days supply	Number of days supply. If the directions say "as needed" or has a dose range, estimate days supply using maximum dosage per day.
Quantity	Total units of medication prescribed. Use the NCPDP billing unit standard format such as "each", "ml", or "gm".
Dispense as written selection code	0 = no product selection mandated 1 = substitution not allowed by prescriber 6 = override for emergency supply. For instate pharmacies only when dispensing emergency supply of a non-preferred drug prescribed by a non-endorsing provider.
National Drug Code	National drug identification code. The code must be entered in a 5-4-2 format. For example, NDC code 0005-3250-23 should be entered 00005 3250 23. NDC code 50419 127 12 should be entered 501419 0127 12.
Drug name	Drug name.
Drug utilization review codes	Enter the appropriate conflict, intervention, and outcome codes.
Remarks	Pertinent information related to prescription.
Prescription clarification code	Enter appropriate value for a refill-too-soon.
Total prescription cost	Total cost of prescription.

Injured Worker Signature:

Injured worker signature	Injured worker signature is only required if the worker is requesting reimbursement.

Need more help or more information?

Go to www.Lni.wa.gov and click on Medical Providers or call the Preferred Drug Line at 888-443-6798.

Need more forms? Go to www.Lni.wa.gov and click on Get a Form or Publication.