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STATE OF WYOMING

DEPARTMENT OF WORKFORCE SERVICES
WORKERS' COMPENSATION DIVISION
CLAIM FOR PHARMACY / MEDICAL SUPPLIES
307-777-7441
PLEASE PRINT OR TYPE IN BLACK INK

Injured Worker Information

▶ **CASE #** _____

SSN #_____ _____
Date of Birth

DATE OF INJURY_____

NAME _____

ADDRESS _____

CITY_____STATE_____ ZIP_____

EMPLOYER _____

ADDRESS _____

CITY_____STATE_____ ZIP _____

Payee Information

FEDERAL TAX ID# OR SSN# _____
Required for payment

PAYEE NAME_____

**ADDRESS_____

CITY _____STATE_____ZIP_____

PHONE # ( ) _____ — _____

INVOICE / PATIENT #_____

NABP# / NCPDP# _____

NOTE: Do not use abbreviations or symbols for drugs or supplies. Itemize supplies dispensed. Provide name of prescribing physician. Payments for drugs will be based upon the Division Rules, Chapter 9 and 10.

Date Dispensed	National Drug Code / Name of Drug or Item	Qty.	TOTAL CHARGES	Invoice or RX # / DAW Code / Refill	Doctor's Name / DEA #	Days Supply

** Pharmacy Name & Location REQUIRED, if different than Payee Name:

TOTAL:

For Division Use Only

I hereby certify under penalty of perjury, that all items billed above were rendered solely on account of the original compensable injury and are true, accurate and complete to the best of my knowledge.

▶ _____ _____
Payee's Signature (required) **Date**

INSTRUCTIONS FOR FILING: **Submit billing no later than the 30th of each month for prior month's services or CLAIM MAY BE DENIED**

MAIL ORIGINAL TO: Division of Workers' Compensation
PO Box 20070
Cheyenne, WY 82003-7001