Texas Department of Insurance
Division of Workers' Compensation

Statement of Pharmacy Services

Send form to workers' compensation insurance carrier

I. COVERAGE VERIFICATION

☒ In accordance with 28 Texas Administrative Code (TAC) §134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file.

II. GENERAL INFORMATION

1. Pharmacy Name, Address and Telephone Number 0	**2. Date of Billing** (mm/dd/yyyy) 0
	3. Pharmacy National Provider Identification Number 0
4. Remit Payment To *(if different from above)*	**5. Invoice Number** 0
	6. Payee Federal Employer Identification Number 0
7. Insurance Carrier Name 0	**8. Employer Name, Address and Telephone Number** 0
9. Injured Employee Name, Address and Telephone Number	**10. Injured Employee Social Security Number** 0
	11. Date of Injury (mm/dd/yyyy) 0
	12. Injured Employee Date of Birth (mm/dd/yyyy) 0
13. Prescribing Doctor Name, Address and Telephone Number 0	**14. Prescribing Doctor National Provider Identification Number** 0
15. Insurance Carrier Claim Number *(if known)* 0	**16. TDI-DWC Claim Number** *(if known)* 0

III. PRESCRIPTION DRUG INFORMATION

17. Dispensed ☒Generic ☐Name Brand		**18. Generic Available?** ☒YES ☐NO		**19. Dispensed As Written Code:** 0		
20. Date Filled 0	**21. Generic NDC** 0	**22. Name Brand NDC** 0	**23. Quantity** 0	**24. Days Supply** 0	**25. Fill Number** 0	**26. Paid by Employee** 0
27. Drug Name and Strength 0				**28. Prescription Number** 0		**29. Amount Billed** 0
30. Preauthorization Number *(if applicable)* 0						
17. Dispensed ☐Generic ☐Name Brand		**18. Generic Available?** ☐YES ☐NO		**19. Dispensed As Written Code:** 0		
20. Date Filled	**21. Generic NDC**	**22. Name Brand NDC**	**23. Quantity**	**24. Days Supply**	**25. Fill Number**	**26. Paid by Employee**
27. Drug Name and Strength				**28. Prescription Number**		**29. Amount Billed**
30. Preauthorization Number *(if applicable)*						

Additional information on required and optional data requirements can be found in 28 TAC §133.10.