## FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF WORKERS' COMPENSATION STATEMENT OF CHARGES FOR DRUGS AND MEDICAL EQUIPMENT & SUPPLIES

Pharmacists & Medical Suppliers - Must complete this billing form in detail to file for reimbursement of services. For Supplies & Equipment - Complete sections 1, 3 & 4For Drug Products - Complete sections 1, 2 & 4

1. EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)  2. EMPLOYEE'S SOCIAL SECURITY # OR DIVISION ASSIGNED #  3. DATE OF ACCIDENT  4. EMPLOYEE'S DOB  5. GENORE  MALE  FEMALE  7. INSURERCARRIER NAME & ADDRESS  3. EMPLOYER'S NAME & ADDRESS  4. EMPLOYER'S NAME & ADDRESS  5. EMPLOYER'S NAME & ADDRESS  5. EMPLOYER'S NAME & ADDRESS  5. EMPLOYER'S NAME & ADDRESS  6. CLAIMS-HANDLING ENTITY & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL SUPPLIER  5. EMPLOYER'S NAME & ADDRESS OF PHARMACY OR MEDICAL								
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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.								