STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

PHARMACY INVOICE

	Claimant's Name: (Last, First, Middle)	Claimant's Address: (Street or PO Box, City, State, Zip)	
	Employer's Business Name:	Employer's Mailing Address:	
	Claimant's Social Security Number – Last four digits:	Date of Injury:	Claim Number:
	Name of Pharmacy:	NABP No:	Check here if payment is to be made to claimant: ☐

PRESCRIPTION DETAIL

Date Written:	Date Filled:	Prescribing Physician:	Prescribing Physician's DEA No:
Prescription Number:	Billing Unit: Check One ☐ Each ☐ ML ☐ GM	National Drug Code: (11 Digits)	
Drug Name:	Generic: ☐ Yes ☐ No	Drug Quantity:	Est. Days Supply:
Refill: ☐ Yes ☐ No	Amount Paid:	Brand Name Justification: (DAW Code from Pharmacist)	
Pharmacy Phone Number: (Include area code)		Claimant's Signature:	Date:
Pharmacist's Signature:		**Date:**	

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Date Written:	Date Filled:	Prescribing Physician:	Prescribing Physician's DEA No:
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Drug Name:	Generic: ☐ Yes ☐ No	Drug Quantity:	Est. Days Supply:
Refill: ☐ Yes ☐ No	Amount Paid:	Brand Name Justification: (DAW Code from Pharmacist)	
Pharmacy Phone Number: (Include area code)		Claimant's Signature:	Date:
Pharmacist's Signature:		**Date:**	

As provided by statutes, this is to certify that the medication(s) was provided as outlined above and that no other or additional charge for such medication(s) has been or will be made against any person, firm or corporation.

	Remarks:	Provider Name and Address:

MUST HAVE RECEIPTS ATTACHED

All pharmacy invoices should be submitted within 30 days from the date of service.
Co-payments are not reimbursable.

INSTRUCTIONS FOR COMPLETING PHARMACY INVOICE

1. CLAIMANT NAME: Enter the full name, last name, first name, and middle initial, with the spelling exactly as it appears on your compensability approval letter or social security card.
2. CLAIMANT ADDRESS: Enter your full mailing address including street number, PO Box or rural route number, city, state and zip code.
3. EMPLOYER BUSINESS NAME: Enter the name of the employer for which you were working on the date of injury or date of last exposure. ("Last exposure" applies only to those claimants suffering from an occupational disease.
4. EMPLOYER MAILING ADDRESS: Enter the full address for the employer listed in item 3.
5. CLAIMANT SOCIAL SECURITY NUMBER: Enter last four digits of the social security number.
6. DATE OF INJURY: Enter the official date of injury or last exposure as listed on the compensability approval letter.
7. CLAIM NUMBER: Enter the claim number assigned by your insurance carrier to the injury claim. This number is found on the compensability approval letter or claimant ID card.
8. NAME OF PHARMACY: Enter the name of the pharmacy that is dispensing the medication.
9. NABP NUMBER: Enter the National Association Board of Pharmacy number.
10. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT: (This block is to be used only by the claimant filing for reimbursement for services for which the claimant has already paid.)
11. DATE WRITTEN: Enter the date the prescription was written by the physician.
12. DATE FILLED: Enter the date the prescription was filled.
13. PRESCRIBING PHYSICIAN'S NAME: Enter the prescribing physician's name. This physician should normally be the "treating physician of record" on file with your insurance carrier.
14. PRESCRIBING PHYSICIAN'S DEA NUMBER: Enter the DEA number for the prescribing physician.
15. PRESCRIPTION NUMBER: Enter the prescription number assigned by the pharmacy.
16. BILLING UNIT (PLEASE CHECK ONE): Each (number of tablets), ML (milliliters) or GM (gram).
17. NATIONAL DRUG CODE: Enter the 11 digit drug code for the prescription being billed. Add leading zeros to any National Drug Code with less than 11 digits. If a compound drug or preparation, write 'COMPOUND RX' in this field.
18. DRUG NAME: Enter the generic description or the brand name for the drug prescribed.
19. GENERIC: Check yes or no.
20. DRUG QUANTITY: Enter the number of tablets, vials, grams or milliliters supplied the claimant.
21. ESTIMATED DAYS SUPPLY: Estimate the number of days the quantity listed in item 20 should last.
22. REFILL: Check yes or no. Check yes if refill is a standing prescription. Check no if dispensed in response to a new prescription.
23. AMOUNT PAID: Enter the charge for the drug being submitted. Include the average wholesale price for the ingredient(s) plus your usual and customary dispensing fee.
24. BRAND NAME JUSTIFICATION (DAW Code from Pharmacist): Enter the DAW code from pharmacist. Accepted DAW codes are:
    - DAW Codes 0, 1, 2, 4 and 5 are the only DAW codes accepted. If the pharmacy is dispensing a brand product with a generic equivalent, your carrier may require that the pharmacy provide an explanation by submitting the appropriate "Dispense as written (DAW) code".
    - DAW Code 0 – No product selection indicated.
    - DAW Code 1 – The Physician specified the brand as "medically necessary" on the face of the prescription.
    - DAW Code 2 – The patient is requesting the brand drug. DAW 2 invoices will be reimbursed at the generic rate, but claimants being required to pay the cost differences between the brand and generic.
    - DAW Code 4 – Pharmacist normally stocks the generic equivalent, but is temporarily out-of-stock.
    - DAW Code 5 – Pharmacist is dispensing the brand as an in-house generic. (Note: Pharmacy will be paid at the generic rate.)
25. PHARMACY PHONE NUMBER (include area code): Enter telephone number of pharmacy.
26. CLAIMANT'S SIGNATURE: Claimant must sign and fill in the date the medication was received.
27. PHARMACIST'S SIGNATURE: Pharmacist must sign and date the invoice. Signature stamps are acceptable.
28. REMARKS: Explain any unusual charges such as compound prescriptions.
29. PROVIDER NAME AND ADDRESS: Enter the name and address which corresponds to the provider number listed in item 9.