Instructions for Completing the

Pharmacy Billing Statement

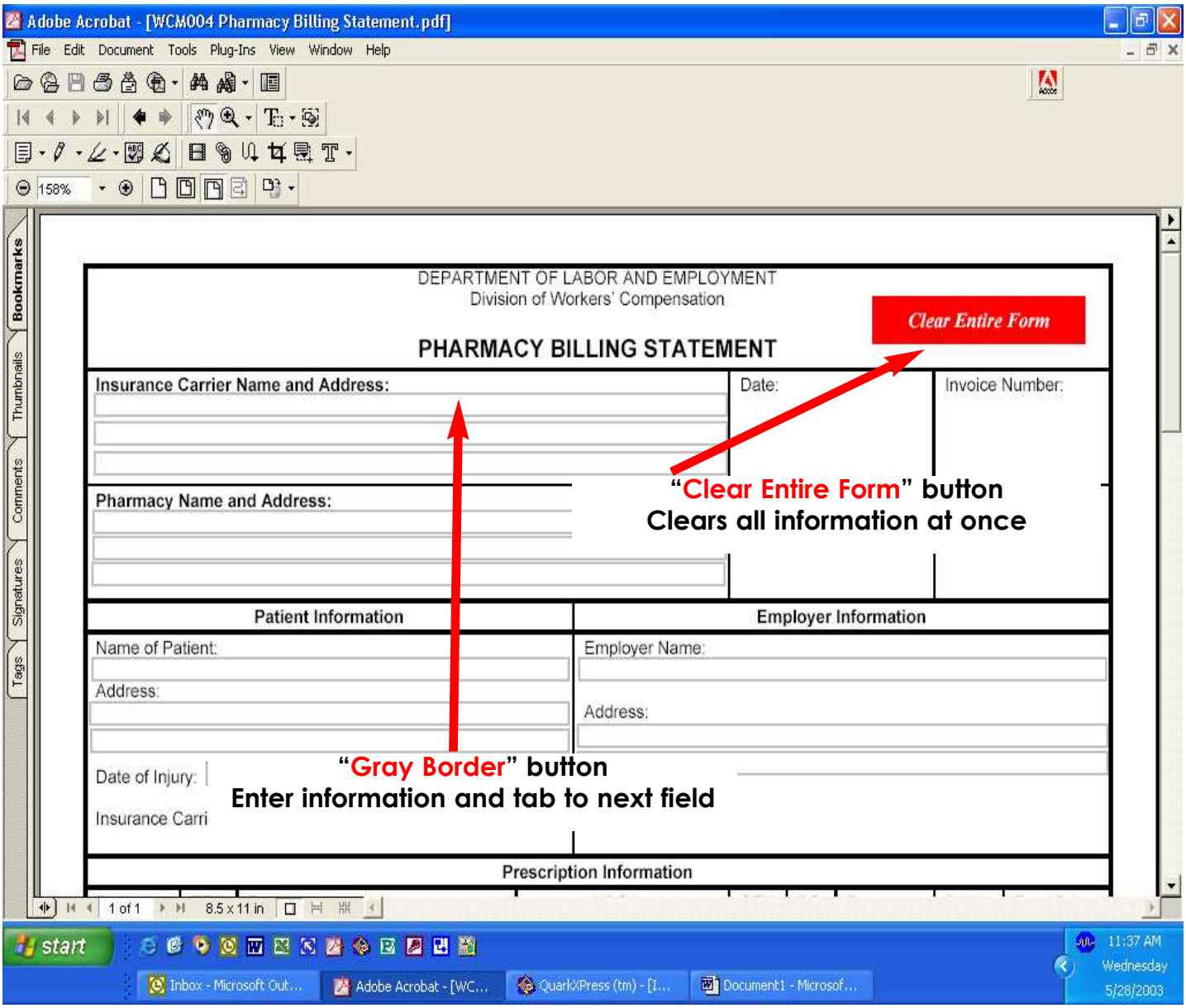
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Insurance Carrier Name and Address" box (field) and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

To fill in a check box, click inside the box with your mouse. "Insurance Carrier Name and Address", "Pharmacy Name and Address", "Patient Information" and "Employer Information" fields are surrounded by a gray border. Type the information in the first field and tab to the next to enter more information.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.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DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
PHARMACY BILLING STATEMENT
Clear Entire Form
Insurance Carrier Name and Address:
Date:
Invoice Number:
Pharmacy Name and Address:
"Clear Entire Form" button
Clears all information at once
Patient Information
Employer Information
Name of Patient:
Employer Name:
Address:
Address:
Date of Injury:
Insurance Carri
"Gray Border" button
Enter information and tab to next field
Prescription Information
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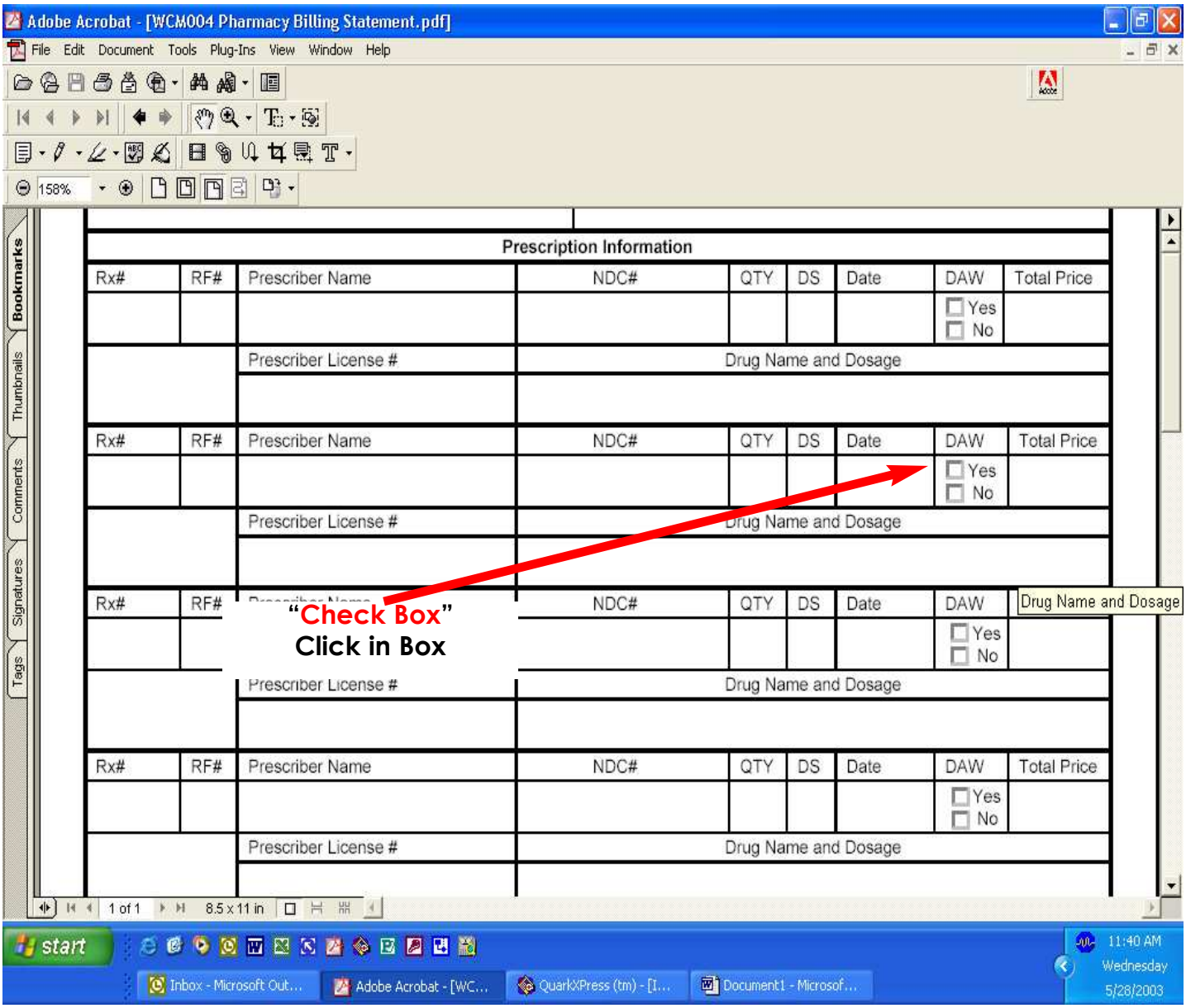
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5/28/2003

DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

PHARMACY BILLING STATEMENT

Insurance Carrier Name and Address:	Date:	Invoice Number:
Pharmacy Name and Address:	Tax ID Number:	Pharmacy NABP Number:

Patient Information	**Employer Information**
Name of Patient:	Employer Name:
Address:	Address:
Date of Injury:	
Insurance Carrier Claim Number:	

Prescription Information

Rx#	RF#	Prescriber Name	NDC#	QTY	DS	Date	DAW	Total Price
							Yes No	
		Prescriber License #	Drug Name and Dosage					
Rx#	RF#	Prescriber Name	NDC#	QTY	DS	Date	DAW	Total Price
							Yes No	
		Prescriber License #	Drug Name and Dosage					
Rx#	RF#	Prescriber Name	NDC#	QTY	DS	Date	DAW	Total Price
							Yes No	
		Prescriber License #	Drug Name and Dosage					
Rx#	RF#	Prescriber Name	NDC#	QTY	DS	Date	DAW	Total Price
							Yes No	
		Prescriber License #	Drug Name and Dosage					

To the Pharmacy: Submit this statement directly to the insurance carrier.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies