



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

**III. PRESCRIPTION DRUG INFORMATION**

|                                                                                    |                 |                                                                                 |              |                                |                 |                      |
|------------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------------------|--------------|--------------------------------|-----------------|----------------------|
| 17. Dispensed <input type="checkbox"/> Generic <input type="checkbox"/> Name Brand |                 | 18. Generic Available? <input type="checkbox"/> YES <input type="checkbox"/> NO |              | 19. Dispensed As Written Code: |                 |                      |
| 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)                                        |                 |                                                                                 |              |                                |                 |                      |
| 17. Dispensed <input type="checkbox"/> Generic <input type="checkbox"/> Name Brand |                 | 18. Generic Available? <input type="checkbox"/> YES <input type="checkbox"/> NO |              | 19. Dispensed As Written Code: |                 |                      |
| 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.