PR-6 (Revised 02/00)

WORKERS' COMPENSATION
REQUEST FOR PRESCRIPTION DRUG REIMBURSEMENT

DATE: _____

NAME: _____ DATE OF INJURY: _____

SOCIAL SECURITY NUMBER: _____

The following prescription drug(s) are being submitted for reimbursement (attach pharmacy receipt):

(ATTACH RECEIPTS HERE)

☐ Please reimburse employee ☐ Please reimburse provider

I certify that the information given is accurate, that all medications for which I am requesting reimbursement directly relate to my workers' compensation claim, and that I have not been reimbursed by any other source for any of the amounts claimed.

Signature: _____ Date: _____