SUBMIT TO WORKERS' COMPENSATION INSURANCE PROVIDER:

NAME: ______________________________ CLAIM#: ______________________________

ADDRESS: ____ DATE OF INJURY: ____________________

EMPLOYER: ______________________________

Please be advised that the above-referenced client is entitled to reimbursement for medical treatment and medication/prescription expenses necessitated by his/her industrial injury:

"OUT OF POCKET EXPENSES" REIMBURSEMENT
(ATTACH RECEIPTS)

Date:	Prescription #:	Doctor:	Name of Medication (description)	Amount:

SIGNATURE: ______________________________ **TOTAL "OUT OF POCKET EXPENSES":**

DATE: ______________________________ **$**____________________