Mail completed forms to:
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

CRIME VICTIMS STATEMENT FOR PHARMACY SERVICES

- Read the instructions on the back before you start.
- When you submit this bill, you are certifying that the prescription information is correct.

☐ Request to reimburse the claimant (Pharmacist signature required below)

☐ This is an insurance co-payment reimbursement.

☐ Request to reimburse pharmacy

		Claim number
	Claimant's SSN (for ID only)	Date of Birth
Pharmacy name & physical address	Claimant's name (Last, First, Middle Initial)	
	Claimant's mailing address	
	City State Zip Code	

Pharmacy L&I provider number or NPI	DEA number	Pharmacy billing date

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code	Drug name				Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:			Prescription clarification code		Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code	Drug name				Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:			Prescription clarification code		Total Prescription Cost:

Date Rx written	Prescribing provider name				Prescribing provider number
Prescription number	Date filled	Refill number	Days supply	Quantity	Dispense as written selection code (DAW 0,1, or 6)
National Drug Code	Drug name				Drug utilization review codes CNFLT: INTRV: OUTCM:
Remarks:			Prescription clarification code		Total Prescription Cost:

The claimant has paid for the above services and prescriptions.

Pharmacist name (please print) Pharmacist signature

RESET

Complete each section.

Claimant Information:

Claimant's social security number	Claimant's social security number. Used to verify claim number.
Claim number	Claim number prescription should be billed to.
Claimant's name	Claimant's legal name in the last, first, middle initial format.
Claimant's mailing address	Claimant's mailing address (can be a PO Box).

Pharmacy Information:

Pharmacy name & address	Pharmacy name and physical location.
Pharmacy L&I provider number or NPI	Pharmacy's L&I provider number or L&I registered NPI.
NCPDC number	National Council for Prescription Drug Programs number.
Pharmacy billing date	Date prescription was filled.

Prescription Information:

Date Rx written	Date prescription was written.
Prescribing provider name	Prescribing provider's name.
Prescribing provider number	Give one of the following numbers for the prescription provider: L&I provider number; NPI; Washington state license number; or DEA number.
Prescription number	Prescription number.
Date filled	Date prescription filled.
Refill number	If the prescription is a refill, enter refill number (0-99). If original prescription, enter "0".
Days supply	Number of days supply. If the directions say "as needed" or has a dose range, estimate days supply using maximum dosage per day.
Quantity	Total units of medication prescribed. Use the NCPDP billing unit standard format such as "each", "ml", or "gm".
Dispense as written selection code	0 = no product selection mandated 1 = substitution not allowed by prescriber 6 = override for emergency supply. For instate pharmacies only when dispensing emergency supply of a non-preferred drug prescribed by a non-endorsing provider.
National Drug Code	National drug identification code. The code must be entered in a 5-4-2 format. For example, NDC code 0005-3250-23 should be entered 00005 3250 23. NDC code 50419 127 12 should be entered 501419 0127 12.
Drug name	Drug name.
Drug utilization review codes	Enter the appropriate conflict, intervention, and outcome codes.
Remarks	Pertinent information related to prescription.
Prescription clarification code	Enter appropriate value for a refill-too-soon.
Total prescription cost	Total cost of prescription.

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