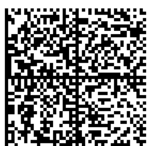
WORK SAFE BC
WORKING TO MAKE A DIFFERENCE



# WORKER PRESCRIPTION CLAIM

This form is to be used to request reimbursement of prescription receipts. Only expenses related to the compensable injury will be paid and only at the applicable WorkSafeBC rate. **Note: All receipts for medical supplies and services and/or vocational rehabilitation expenses should be claimed on a form 3A, *Worker Medical Supply and Services Claim*.**

**PAYMENT SERVICES:** Phone 604 276-3085
Toll-free 1 888 422-2228

**FAX: 604 233-9777**
Toll-free **1 888-922-8807**

**MAIL:** Payment Services, WorkSafeBC
PO Box 94460 Stn Main
Richmond BC V6X 8V6

**Requests for reimbursement may not be paid if all mandatory information is not provided on this form. Mandatory fields are indicated by * below.**

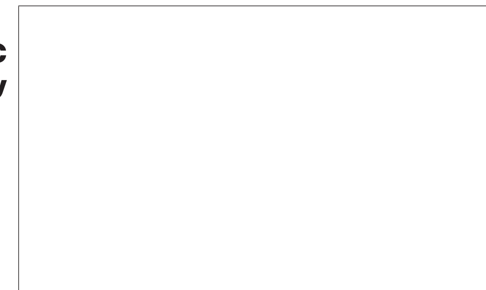
| Worker last name* | First name* | Personal health number* *(from BC CareCard)* | WorkSafeBC claim number* |
|---|---|---|---|
| Address line 1* | | Address line 2 | |
| City* | | Province/State* | Country *(if not Canada)* | Postal code/Zip* |
| Daytime phone number* *(please include area code)* | | Has your address changed?* Yes ☐ No ☐ | Date of birth* *(yyyy-mm-dd)* |
| Company or employer name* | | Nature of injury or illness* | |

| | Quantity and name of medication* | Date of purchase* *(yyyy-mm-dd)* | Drug identification number (DIN)* | Rx number* | Indication for use* *(example: pain killer, antibiotic, antidepressant etc.)* | Amount paid by worker* | Amount paid by Pharmacare* *(if applicable)* | Name of physician prescribing medication* |
|---|---|---|---|---|---|---|---|---|
| | **EXAMPLE: Tylenol #3** | **2007-04-29** | **02163926** | **123456** | **Pain-killer** | **$10.00** | **$2.00** | **Dr. ABC** |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |

***Do not** submit original receipts. Submit **copies only** of receipts. Please write your claim number on each copy submitted. WorkSafeBC does **not** return receipts. Please **keep original receipts** as these may be required for audit purposes.*

| I certify that I incurred these expenses. I understand that it is considered fraud or misrepresentation to claim the same expenses twice from other institutions. I authorize release of any information or record requested in respect of this claim to WorkSafeBC or its agents and certify that the information given is true, correct, and complete to the best of my knowledge. | |
|---|---|
| Signature* | Date* *(yyyy-mm-dd)* |

**WorkSafeBC use only**



Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.