North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

Emp. Code #_____

Carrier Code #_____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employer FEIN_____

Employee's Name

Address

City State Zip

( ) Home Telephone

XXX-XX- Last 4 Digits of SSN

☐ M ☐ F Sex

/ / Date of Birth

Employer's Name ( ) Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) Carrier's Telephone Number

( ) Fax Number

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
				TOTAL	**$**

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature

Carrier's approval

Reimburse employee
Yes ☐ no ☐

Reimburse drug store
Yes ☐ no ☐

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.

EMPLOYEE: Mail your bill in duplicate promptly to employer and/or insurance carrier

FORM 25P

NCIC - MEDICAL BILLING SECTION
4337 MAIL SERVICE CENTER
RALEIGH, NC 27699-4337
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688- 8349
WEBSITE: HTTP://WWW.IC.NC.GOV/