



## **Worker Prescription Claim**

Please use this form to request reimbursement of prescription receipts for expenses related to the accepted injury on your claim. Approved expenses will be paid at the applicable WorkSafeBC rate. Use a Worker Medical Supply and Services Claim form (form 3A) to submit receipts for medical supplies and services or a Worker Supply and Services Claim form (form 3B) for vocational rehabilitation expenses.

Submit copies of receipts as we are not able to return your receipts. Write your name and claim number on each copy submitted and keep your original receipts as they may be required for audit purposes.

Pleas	se complet	e every field on this form.	We may not be al	ble to reimburs	se you if inf	ormation	is missin	g from you	r form.				
Wor	ker's last na	ame	First name	First name				Personal health number (BC Services Card/CareCard)				WorkSafeBC claim number	
Mail	ing address	for payment		City				Province/State Postal		stal code	:/Zip	Zip Country (if not Canada)	
	Has your address changed in the last six months?  Daytime phone number (include area code)  Nature of injury or illness  Nature of injury or illness  Please list each prescription separately in the table below.												
	Quantity	Name of medication	Date of purchase (yyyy-mm-dd)	Drug identification number (DIN)			<b>ed use</b> ple: pain kille ssant, etc.)	er, antibiotic,	Amour by wo			me of physician escribing medication	
e.g.	50	Example: Tylenol 3	2021-04-30	02163926	123456	Pain kill	er		\$10	0.00	Dr. Al	BC	
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
I certify that I incurred these expenses. I understand that it is considered fraud or misrepresentation to claim the same expenses from more than one source. I authorize the 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.									WorkSafeBC use only				
Sigr	ature		Date (yyyy-mm	Date (yyyy-mm-dd) I have i		ncluded copies of receipts							
			233.6889 free 1.888.960.6889	1.888.960.6889 PO Box		ent Services, WorkSafeBC x 94460 Stn Main uver BC V6X 8V6							

WorkSafeBC collects information on this form for the purposes of administering and enforcing the Workers Compensation Act. That Act, along with the Freedom of Information and Protection of Privacy Act, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's FIPP Office, at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or email FIPP@worksafebc.com, or call 604.279.8171.

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