TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☐ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DWC FORM-66 instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #:	2. Date of Billing:
	3. Pharmacy's NCPDP # (Formerly NABP):
4. Remit Payment To (if different from above):	5. Invoice #:
	6. Payee's FEIN:
7. Carrier's Name and Address:	8. Employer's Name, Address, and Phone #:
9. Injured Employee's Name and Address, and Phone #:	15. Prescribing Doctor's Name, Address, and Phone #:
10a. Injured Employee's ID #: / 10b. ID Jurisdiction: / 10c. ☐SSN ☐DL# ☐Passport ☐Visa ☐Green Card	16. Prescribing Doctor's DEA #:
11. DOI: / 12. DOB: / 13. CLAIM # (if known):	14. Carrier's Claim # (if known):

Section 2

17. ☐Generic Dispensed ☐Name Brand Dispensed		18. Generic Available? ☐YES ☐NO		19. ☐Dispensed as Written ☐Dispensed per Injured Employee request		
20. Date Filled:	21. Generic NDC:	22. Name Brand NDC:	23. Quantity:	24. Days Supply:	25. Refills Remaining:	26. Paid by Employee:
27. Drug Name and Strength:			28. Rx #:			29. Amount Billed:
17. ☐Generic Dispensed ☐Name Brand Dispensed		18. Generic Available? ☐YES ☐NO		19. ☐Dispensed as Written ☐Dispensed per Injured Employee request		
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27. Drug Name and Strength:			28. Rx #:			29. Amount Billed:

Instructions for Completing
DWC FORM-66
STATEMENT OF PHARMACY SERVICES

The pharmacy shall submit a DWC FORM-66 for each prescribing doctor.

VERIFICATION STATEMENT

Pursuant to Texas Labor Code §413.0141, the Division has adopted rule 134.501 that guarantees the reimbursement of pharmaceutical services sufficient to cover the first seven days following the date of injury. This guarantee only applies if the dispensing health care provider: 1) verifies the employer's workers compensation insurance coverage and 2) verbally confirms with the carrier or the employer that an injury has been reported to the employer. This block allows the dispensing provider to invoke the initial coverage provisions in Rule 134.501 by affirming that the provider verified that coverage exists and confirmed that an injury was reported. However the provider is not required to invoke this guarantee.

SECTION 1 BILLING INFORMATION (R)=Required, (C)=Conditional (only required in certain conditions), (O)=Optional

1. Pharmacy's name, address, city, state, ZIP code, and phone #. (R)
2. Provide the date the bill was sent to the insurance carrier. (R)
3. Number assigned to the pharmacy by the National Council for Prescription Drug Programs (NCPDP, formerly NABP). (R)
4. Name and address of the party to whom payment will be made, if different from the pharmacy. (C)
5. Pharmacy's invoice number assigned to the billing statement. (R)
6. Federal Tax Identification Number (FEIN) of the party to whom payment will be made. (R)
7. Workers' compensation insurance carrier's name, address, city, state, and ZIP code. (R)
8. Employer's name, address, city, state, and ZIP code, (and phone # if known). (R)
9. Injured employee's name, address, city, state, and ZIP code, (and phone # if known). (R)
10 a, b, & c. Provide the injured employee's identification number, the jurisdiction (e.g. US, Mexico, Texas) that issued the number, and check the box corresponding with the type of identification listed (e.g., Social Security Number, driver's license/ID, green card, passport, or visa). (R)
11. Date the injury occurred. (R)
12. Injured employee's date of birth. (R)
13. Number assigned by DWC to the injured employee's claim, if known. (O)
14. Unique claim identification number assigned by the insurance carrier, if known. (O)
15. Prescribing doctor's name, professional title (e.g. MD), address, city, state, zip code, and phone #. (Only one prescribing doctor per form) (R)
16. Number assigned to the prescribing doctor by the Drug Enforcement Agency. (R)

SECTION 2 PRESCRIPTION INFORMATION

17. Indicate if the drug dispensed was a generic or name brand drug. (R)
18. Indicate yes or no if generic was available when Name Brand is prescribed and/or dispensed (Required only when field 17 indicates name brand was dispensed). (C)
19. Indicate if the drug was dispensed as written or as requested by the injured employee (Required only when field 17 indicates name brand was dispensed). (C)
20. Provide the date the prescription was filled. (R)
21. Provide the National Drug Code (NDC) for the Generic drug (required even when Name Brand is dispensed). (R)
22. Provide the National Drug Code (NDC) for the Name Brand drug when dispensed (Required only when field 17 indicates name brand was dispensed). (C)
23. Provide the quantity dispensed. (R)
24. Provide the number of days the prescription drug should last based upon the prescription. (R)
25. Provide the number of refills remaining after this one is filled. (R)
26. Provide the amount paid by the employee when the employee chooses to pay the difference between the generic and the brand name drug. (C)
27. Provide the name and strength of the drug dispensed. (R)
28. Provide the prescription number assigned by the pharmacy. (R)
29. Provide the amount billed for the prescription. (R)

INSURANCE CARRIER INFORMATION

INDICATE THE DATE THE CARRIER RECEIVED THE BILL

Payment information shall be provided using DWC FORM-62, EOB, in accordance with Rule 133.304.