Bureau of Workers' Compensation

Request for Injured Worker Outpatient Medication Reimbursement (C-17)

The Request for Injured Worker Outpatient Medication Reimbursement (C-17) is used for medication reimbursement, including over-the-counter items. The medication must be written as a prescription and dispensed by an enrolled pharmacy. Medication purchased at a physician's office for at-home use are non-reimbursable. A C-17 is not used for medical supplies, durable medical equipment, and other non-drug reimbursement items. These items should be billed directly to the managed care organization (MCO).

Instructions – to avoid submitting a C-17, the pharmacy can process a point-of-sale transaction.

- A separate C-17 is required for each pharmacy.
- Complete all sections **including injured worker and pharmacist signature.**
- Prescription labels or a pharmacy printout with pricing information must be sent. Photocopies are acceptable. A pharmacy cash register receipt **is not** acceptable.
- Change Healthcare must receive the C-17 within **1 (one) year** from the date of service.
- Mail the completed C-17 and prescription labels with pricing information to **Change Healthcare**. Mailing a C-17 to BWC could result in a delay of your reimbursement.

C-17 Mailing Address	**Questions**
Change Healthcare	Change Healthcare
P.O. Box 769	1-888-292-5229
Augusta, ME 04332	

Reimbursement – to avoid a delay in reimbursement, wait to mail the C-17 until after BWC has approved the claim.

- Within three (3) weeks of receiving a completed C-17, Change Healthcare will mail a check for reimbursement.
- Within seven (7) days of receiving a C-17 that could not be processed, Change Healthcare will mail a letter explaining why reimbursement could not be processed.
- Reimbursement will be considered for prescriptions that meet the requirements of BWC's outpatient medication formulary and payment rules.
- Brand-name medications are reimbursed at the generic drug price when a generic medication was available.

C-17 reminders

☐ Complete every section on the form including both signatures.

☐ Include the pharmacy labels or a pharmacy printout with pricing information.

☐ **A pharmacy cash register receipt is not acceptable.**

☐ Ensure your claim has been approved by BWC.

☐ Mail completed C-17 and documentation to Change Healthcare **not** BWC.

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Injured worker information		
Date of request	Date of injury	BWC claim number
Injured worker name		
Injured worker address *(street or PO Box, city, state, and zip code)*		

Pharmacy information		
Pharmacy *(name and store number)*	NPI number	Pharmacy phone
Pharmacy address *(street or P.O. Box, city, state, and ZIP code)*		

Prescription detail			
Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)
Drug name, strength, and dosage form	National drug code (NDC)	Quantity	
Days' supply	Prescriber's name	Prescriber's NPI number	
Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)
Drug name, strength, and dosage form	National drug code (NDC)	Quantity	
Days' supply	Prescriber's name	Prescriber's NPI number	
Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)
Drug name, strength, and dosage form	National drug code (NDC)	Quantity	
Days' supply	Prescriber's name	Prescriber's NPI number	
Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)
Drug name, strength, and dosage form	National drug code (NDC)	Quantity	
Days' supply	Prescriber's name	Prescriber's NPI number	

Any person who obtains compensation, medical or pharmaceutical benefits from BWC or self-insuring employers by knowingly misrepresenting orconcealing facts, making false statements, or accepting compensation, medical or pharmaceutical benefits to which he/she is not entitled, is subject to felony criminal prosecution for fraud. By signing below, I certify I have read and understand the statements above and agree with these conditions.

I certify below the information on this form is true and correct to the best of my knowledge and belief.

Injured worker's signature	**Date**
Pharmacist's signature	**Date**