



ABRAMS LANDAU, Ltd.
INJURY LAW FIRM

PRESCRIPTION/ PHARMACEUTICAL COSTS

Claimant: _____ **Date of Injury:** _____

JCN: _____ **Claim No.:** _____

| Date of Treatment | Specific Name of Medication or Product | Amount paid \$ |
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Please record the following information for any prescriptions or other prescribed medical needs. Be sure to submit the receipts along with the completed form.