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Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number (required) 01	Loc (req) 02	Billing NPI (optional) 03	Telephone Number 04

Patient's Name: Last, First (required) 05	Member ID (Required). 06	Member's Date of Birth (Required mmddccyy) 07	Emergency (Y or N) 08	Pregnancy (Y or N) 09	NH Pt. (Y or N) 10

Prescription Number (Required) 11	Date Prescribed (Required) 12	Date Dispensed (Required) 13	NDC Number (Required) 14	Quantity (required) 15	Days 16

Brand Medically Necessary 17	Refill 18	Individual Prescriber's NPI Number (Required) 19	Individual Prescriber's Name: Last, First (Required) 20

Provider's Name and Address 25	This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law. I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.	
	Signature of Provider or Representative (Required) 26	Date Billed (Required) 27

Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23	Usual and Customary 24

Mail Completed Claim Form to:

EDS P.O. Box 18650