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State of Oklahoma  
 Oklahoma Health Care Authority  
 Prescription 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 Dispersed (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.
26	Signature of Provider or Representative (Required)  Date Billed (Required)  27

Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23	Usual and Customary 24
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**Mail Completed Claim Form to:**  
 EDS  
 P.O. Box 18650  
 Oklahoma City, OK 73154