Drug Claim Form

PLEASE PRINT CLEARLY

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

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

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

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

Provider's Name and Address	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.	
25	Signature of Provider or Representative (Required) 26	Date Billed (Required) 27

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

Mail Completed Claim Form to:

DXC Technology | P.O. Box 18650, Oklahoma City, OK 73154