ICN (DO NOT WRITE IN THIS SPACE)	ORIGINAL	PLEASE STAMP
	SERVICE DATE MO. YR.	PHARMACY NAME PHARMACY NUMBER

ROUTE ORIGINAL TO
EDS
P.O. BOX 300001
RALEIGH, NC 27622-3001

PHARMACY LOCATION
6 Rest Home
7 Intermediate Care Facility
8 Skilled Nursing Facility

Please Print or Type

BLACK OR DARK BLUE ONLY

V

AMOUNT BILLED

	MEDICAID ID NUMBER	RECIPIENT'S NAME LAST	FIRST	LOC	SEX	RX NUMBER	O/R	PRESCRIBER NAME OR DEA NUMBER	OTHER COV.
0									
1									
2									
3									
4									
5									
6									
7									
8									
9									

DAY FILLED	DRUG NAME	STRENGTH	DOSAGE	MFG.	NDC	QUAN	EST. DAYS SUPPLY	EPSDT	FAM. PLAN	DOLLARS	CENTS

(FOR EACH COMPOUNDED ℞ LIST NAME, STRENGTH, QUANTITY, MFG. AND COST OF EACH INGREDIENT BELOW)

CLAIM TOTAL

"THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT, OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS."

SUBMISSION DATE
MO. DAY YR.

PAGE NO.

X
CLAIMANT SIGNATURE

372-012 (12-92)