SERVICE DATE

MO. YR.

MEDICAID PROVIDER NUMBER

PHARMACY NAME

PHARMACY NPI NUMBER

ROUTE ORIGINAL TO

HP ENTERPRISE SERVICES
P.O. BOX 30968
RALEIGH, NC 27622

PHARMACY LOCATION

6 Assisted Living Facility
7 Intermediate Care Facility
8 Skilled Nursing Facility

Please Print or Type

BLACK OR DARK BLUE INK

V

AMOUNT BILLED

	MEDICAID ID NUMBER	RECIPIENT'S NAME - LAST, FIRST	LOC	SEX	RX NUMBER	O/R	PRESCRIBER NPI 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, NDC, 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.

CLAIMANT SIGNATURE