[redacted]

ACS
HAWAII STATE MEDICAID FEE FOR SERVICE PROGRAM
Attention: Claims
P.O BOX 967, HENDERSON, NC 27536

PRESCRIPTION DRUG CLAIM

Identification Number [1]	Recipient's Name [2]	Date of Birth [3]	**Pharmacy NPI** [4]
Pharmacy Name [5]		Pharmacy Address [6]	
Prescriber's NPI [7]	Prescriber's DEA (for C II – V drugs)[8]	Prescriber's Name[9]	
Other Drug or Liability Coverage [10]es ☐ No ☐ Name of Coverage _____	Date of Accident [11]	Is the illness or injury: [12] Work Related Yes ☐ No ☐ Automobile Yes ☐ No ☐ Third Party? Yes ☐ No ☐ Other Accident? Yes ☐ No ☐	ICF-MR/ICF/SNF? [13] No ☐ Yes ☐

									Submitted Charge[27]	Paid by TPL Amount [28] (Attach a copy of EOB)	TOTAL [29]
1	RX Number [14]	Metric Quantity [15]	Billing Unit [16] ☐ Gm ☐ ML ☐Each	Days Supply [17]	NDC [18] ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code [19]				
	Date [20]	☐New ☐Refill [21]	Drug Name/Strength [22]		DAW Code [23]	Prior Authorization Number [24]	Reason for Refill Too Soon Override [25]			✓ If Compound [26] ☐	
2	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code				
	Date	☐New ☐Refill	Drug Name/Strength		DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override			✓ If Compound ☐	
3	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code				
	Date	☐New ☐Refill	Drug Name/Strength		DAW Code	Prior Authorization Number.	Reason for Refill Too Soon Override			✓ If Compound ☐	
4	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code				
	Date	☐New ☐Refill	Drug Name/Strength		DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override			✓ If Compound ☐	
5	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code				
	Date	☐New ☐Refill	Drug Name/Strength		DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override			✓ If Compound ☐	
6	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___		Diagnosis Code				
	Date	☐New ☐Refill	Drug Name/Strength		DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override			✓ If Compound ☐	

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 false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws. I hereby agree to keep such records as are necessary to fully disclose the extent of service provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

Provider's Signature _____ Date _____