PLEASE PRINT CLEARLY

PLEASE PRINT	CLEARLY	′								DRI	UG CLAI	M FORM
1 MEMBER N.	PRESCRIBER NPI			EMERGENCY		PREG	PATIENT RES	PLACE OF SVC				
01	02			03		04	05	06				
RID NO PRESCRIPTION NO			DAW CODE		REFILL NO	1	QU	ANTITY D	ISPENSED	DAYS SUPPLY	U&C CHARGE	
07		08		09		10		11			12	13
DATE PRESC	DATE DIS	P	NDC NUMBE		OTHER	R PAYER AMT F		Ī	OTHER	COVERAGE CODE	OTHER PA	YER-PATIENT
											RESPONS	SIBILITY AMT
14	15	E10.0E	16	Inneronine in	17				18	loose	19	In the of the
2 MEMBER N.	AME: LAST,	FIRST		PRESCRIBER NPI			EMERGEN	CY		PREG	PATIENT RES	PLACE OF SVC
01				02			03			04	05	06
RID NO		PRESCRIPT	ION NO	DAW CODE		REFILL NO	ľ	QU	ANTITY D	ISPENSED	DAYS SUPPLY	U&C CHARGE
07		ng.		09		10		11			12	13
DATE PRESC	DATE DIS	P	NDC NUMBE		OTHER	R PAYER AMT F		Ī	OTHER	COVERAGE CODE		YER-PATIENT
											RESPONS	SIBILITY AMT
14	15	FIDCT	16	PRESCRIBER NPI	17		EMERGEN	CV 1	18	PREG	19	DI ACE OF SVC
3 MEMBER N.	AIVIE: LAST,	FIKST		PRESCRIBER NPI			EWIERGEN	CY		PREG	PATIENT RES	PLACE OF SVC
01				02			03			04	05	06
RID NO		PRESCRIPT	ION NO	DAW CODE		REFILL NO	ľ	QU	ANTITY D	ISPENSED	DAYS SUPPLY	U&C CHARGE
07		08		09		10	:	11			12	13
DATE PRESC	DATE DIS	Р	NDC NUMBE	R	OTHER	R PAYER AMT F	PAID		OTHER	COVERAGE CODE		SIBILITY AMT
14	15 16		16	17			18			19		
4 MEMBER NAME: LAST, FIRST			10	PRESCRIBER NPI			EMERGENCY			PREG	PATIENT RES	PLACE OF SVC
01				02			03			04	05	06
RID NO		PRESCRIPTION NO		DAW CODE		REFILL NO		QUANTITY D		ISPENSED	DAYS SUPPLY	U&C CHARGE
07		00				40						40
DATE PRESC	DATE DIS	08 P	NDC NUMBE	09 ER	OTHER	10 R PAYER AMT F		11	OTHER	COVERAGE CODE	12 OTHER PA	13 YER-PATIENT
											RESPONSIBILITY AMT	
14 15		16		17				18			19	
5 MEMBER NAME: LAST, FIRST			PRESCRIBER NPI			EMERGENCY			PREG	PATIENT RES	PLACE OF SVC	
01				02			03			04	05	06
RID NO		PRESCRIPT	10N NO	DAW CODE		REFILL NO	ľ	QU	ANTITY D	ISPENSED	DAYS SUPPLY	U&C CHARGE
07		08		09		10	:	11			12	13
DATE PRESC	ATE PRESC DATE DISP		NDC NUMBE	ER	OTHER	R PAYER AMT PAID		OTHER COVERAGE CODE		COVERAGE CODE	OTHER PAYER-PATIENT RESPONSIBILITY AMT	
14	15 1		16	16		17		18			19	
PROVIDER'S NAME		ESS			This is to	certify that the fo	regoing inform			urate, and complete. I un	derstand that payment	and satisfaction of this
 20					claim wi	ll be from federal a	and state funds,	, and	that any fal	sification of claims, state		r concealment of material
Provider NPI		fact may be prosecuted under applicable federal or state laws. I, the undersigned, being aware of restricted funds in the IHCP Program, agree to accept as full payment for services enumerated on										
21							allowance determined by the Department or its designee. I further certify that no e billed to the patient. I further recognize that any difference of opinion concerning					
					charges a	and/or allowance for	or this claim sh	all b	e adjudicate	d as specified in the Prov	ider Module.	
PROVIDER TYPE												
22 PHARMACY				SIGNATURE OF		ITATI) (F					DATE D = 2	
□ PHYSICIAN □ DENTIST			ı	PROVIDER OR RE	EPKESEN	NIATIVÉ				24	DATE BILLED	
OTHER			'	_								

MAIL COMPLETED CLAIM FORM TO:

OptumRx - Manual Claims Processing PO Box 29044 Hot Springs, AR 71903