PLEASE PRINT CLEARLY

DRUG CLAIM FORM

1	MEMBER NAME: LAST, FIRST 01	PRESCRIBER NPI 02	EMERGENCY 03	PREG 04	PATIENT RES 05	PLACE OF SVC 06	
RID NO 07	PRESCRIPTION NO 08	DAW CODE 09	REFILL NO 10	QUANTITY DISPENSED 11	DAYS SUPPLY 12	U&C CHARGE 13	
DATE PRESC 14	DATE DISP 15	NDC NUMBER 16	OTHER PAYER AMT PAID 17	OTHER COVERAGE CODE 18	OTHER PAYER-PATIENT RESPONSIBILITY AMT 19		
2	MEMBER NAME: LAST, FIRST 01	PRESCRIBER NPI 02	EMERGENCY 03	PREG 04	PATIENT RES 05	PLACE OF SVC 06	
RID NO 07	PRESCRIPTION NO 08	DAW CODE 09	REFILL NO 10	QUANTITY DISPENSED 11	DAYS SUPPLY 12	U&C CHARGE 13	
DATE PRESC 14	DATE DISP 15	NDC NUMBER 16	OTHER PAYER AMT PAID 17	OTHER COVERAGE CODE 18	OTHER PAYER-PATIENT RESPONSIBILITY AMT 19		
3	MEMBER NAME: LAST, FIRST 01	PRESCRIBER NPI 02	EMERGENCY 03	PREG 04	PATIENT RES 05	PLACE OF SVC 06	
RID NO 07	PRESCRIPTION NO 08	DAW CODE 09	REFILL NO 10	QUANTITY DISPENSED 11	DAYS SUPPLY 12	U&C CHARGE 13	
DATE PRESC 14	DATE DISP 15	NDC NUMBER 16	OTHER PAYER AMT PAID 17	OTHER COVERAGE CODE 18	OTHER PAYER-PATIENT RESPONSIBILITY AMT 19		
4	MEMBER NAME: LAST, FIRST 01	PRESCRIBER NPI 02	EMERGENCY 03	PREG 04	PATIENT RES 05	PLACE OF SVC 06	
RID NO 07	PRESCRIPTION NO 08	DAW CODE 09	REFILL NO 10	QUANTITY DISPENSED 11	DAYS SUPPLY 12	U&C CHARGE 13	
DATE PRESC 14	DATE DISP 15	NDC NUMBER 16	OTHER PAYER AMT PAID 17	OTHER COVERAGE CODE 18	OTHER PAYER-PATIENT RESPONSIBILITY AMT 19		
5	MEMBER NAME: LAST, FIRST 01	PRESCRIBER NPI 02	EMERGENCY 03	PREG 04	PATIENT RES 05	PLACE OF SVC 06	
RID NO 07	PRESCRIPTION NO 08	DAW CODE 09	REFILL NO 10	QUANTITY DISPENSED 11	DAYS SUPPLY 12	U&C CHARGE 13	
DATE PRESC 14	DATE DISP 15	NDC NUMBER 16	OTHER PAYER AMT PAID 17	OTHER COVERAGE CODE 18	OTHER PAYER-PATIENT RESPONSIBILITY AMT 19		

PROVIDER'S NAME AND ADDRESS
☐ 20

Provider NPI
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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 laws.

I, the undersigned, being aware of restricted funds in the IHCP Program, agree to accept as full payment for services enumerated on this claim form, for this IHCP 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 Module.

PROVIDER TYPE
22
☐ PHARMACY
☐ PHYSICIAN
☐ DENTIST
☐ OTHER

SIGNATURE OF
PROVIDER OR REPRESENTATIVE
☐ 23

DATE BILLED
24

MAIL COMPLETED CLAIM FORM TO:

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