**NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**

**PHARMACY CLAIM FORM**

### PROVIDER ID NUMBER

### DATE FILLED

### ESN CODE

### ORIGINAL CLAIM REFERENCE NUMBER

### RECIPENT ID NUMBER

### DATE OF BIRTH

### SEX

### RECIPENT NAME

### OTHER INSURANCE CODE

### RECIPIENT ID NUMBER

### DATE OF BIRTH

### SEX

### RECIPIENT NAME

### OTHER INSURANCE CODE

### DRUG/SUPPLY CODE

### QUANTITY DISPENSED

### DAYS SUPPLY

### TOTAL AMOUNT CHARGED

### CASE MGR. I.D.

### TOTALS

---

**MEDICARE**

### PRIOR APPROVAL/AUTHORIZATION NO.

### FOR OFFICE USE ONLY

### FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

<table>
<thead>
<tr>
<th>INGREDIENTS QUANTITY PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOSAGE FORM AND DIRECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL INGREDIENT COST</td>
</tr>
<tr>
<td>COMPOUNDING FEE</td>
</tr>
<tr>
<td>DISPENSING FEE</td>
</tr>
<tr>
<td>AMOUNT CHARGED</td>
</tr>
</tbody>
</table>

---

**DISCLAIMER**

This sample is not for submission.
I understand the significance of the process and I am in compliance with all relevant laws and regulations. I certify that the services were rendered at the location listed in the "place of service" field.

I have read the Medicaid Management Information Systems Provider Manual as it relates to this claim form, and all revisions and updates thereof; all claims are made in full compliance with the requirement that care, services, and supplies for which claim is made are medically necessary for the treatment of the named recipient.

Entities:
(Person authorized to certify for the group) certifies that the person identified as the service provider listed in the "place of service" field.

I have read the Medicaid Management Information Systems Provider Manual as it relates to this claim form, and all revisions and updates thereof; all claims are made in full compliance with the requirement that care, services, and supplies for which claim is made are medically necessary for the treatment of the named recipient.

All:

The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge, is due from, provider, and (2) accept the claim data on this form as original evidence of care, services, and supplies. By making this claim, I understand and agree that (i) the entity shall be subject to and bound by all rules, regulations, policies, standards, fee codes, and procedures of the New York State Department of Social Services as set forth in the Medicaid Management Information Systems Provider Manual, and (ii) accept the claim data on this form as original evidence of care, services, and supplies for which claim is made.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.