60-6 (10/01)

Kansas Medical Assistance Programs

P. O. Box 3571 Provider Line: 1-800-933-6593
Topeka, KS 66601-3571 Consumer Line: 1-800-766-9012

PHARMACY CLAIM

PLEASE TYPE OR PRINT

LINE	1 BENEFICIARY LAST NAME	2 FIRST NAME (2 POS.)	3 BENEFICIARY'S IDENTIFICATION NUMBER	4 NURSING HOME Y OR N	5 E P S D T Y OR BLANK	6 OTHER INS. Y OR BLANK	7 PRESCRIPTION NUMBER	8 PRESCRIBING PHYSICIAN MEDICAID NUMBER	9 DATE DISPENSED MM DD YY	10 NATIONAL DRUG CODE (NDC)	11 REFILL CODE	12 METRIC QUANTITY	13 DAYS SUPPLY	14 DIAGNOSIS/ REFERENCE	15 TOTAL CHARGE
0															
1															
2															
3															
4															
5															
6															
7															
8															
9															

LINE 16. REMARKS (COMPOUNDS, OTHER INS. AMOUNT, ETC.)

17. TOTAL AMOUNT BILLED

18.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and Medical Assistance Program and to furnish information regarding any payments claimed for providing such services as the State Agency, its designee, or Health and Human Services may request. I further agree to accept, as payment in full, subject to audit, the amount paid by the Medicaid (Medical Assistance) program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment and spenddown.

I certify that (1) the services listed above are medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess, of regular fees; (3) the information provided hereon is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or 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.

RETURN ORIGINAL TO: MEDICAID

19. PROVIDER NAME AND NUMBER

20. SIGNATURE

21. DATE

8810051278 02/2008, PR Donnelley. All rights reserved. 0667