

GROUP I.D. _____ I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. () _____

STATE & ZIP CODE _____ FAX NO. () _____

| FOR OFFICE USE ONLY | |
|---------------------|--|
| | |
| | |
| | |

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

ADDRESS _____

PATIENT / AUTHORIZED REPRESENTATIVE _____

CITY _____ STATE _____ ZIP CODE _____

CARRIER I.D. (6) _____ EMPLOYER PHONE NO. _____

DATE OF INJURY _____ CLAIM (7) REFERENCE I.D. _____

**ATTENTION RECIPIENT
PLEASE READ
CERTIFICATION
STATEMENT ON
REVERSE SIDE**

1

1

| PRESCRIPTION / SERV. REF. # | QUAL. (8) | DATE WRITTEN MM DD CCYY | DATE OF SERVICE MM DD CCYY | FILL# | QTY DISPENSED (9) | DAYS SUPPLY |
|-----------------------------|-----------|----------------------------|-------------------------------|-------|-------------------|-------------|
| | | | | | | |

| | |
|--|----------------------------|
| | INGREDIENT COST SUBMITTED |
| | DISPENSING FEE SUBMITTED |
| | INCENTIVE AMOUNT SUBMITTED |
| | OTHER AMOUNT SUBMITTED |
| | SALES TAX SUBMITTED |
| | GROSS AMOUNT DUE SUBMITTED |
| | PATIENT PAID AMOUNT |
| | OTHER PAYER AMOUNT PAID |
| | NET AMOUNT DUE |

| PRODUCT / SERVICE I.D. | QUAL. (10) | DAW CODE | PRIOR AUTH # SUBMITTED | PA TYPE (11) | PRESCRIBER I.D. | QUAL. (12) |
|------------------------|------------|----------|------------------------|--------------|-----------------|------------|
| | | | | | | |

| DUR/PPS CODES (13) | BASIS COST (14) | PROVIDER I.D. | QUAL. (15) | DIAGNOSIS CODE | QUAL. (16) |
|--------------------|-----------------|---------------|------------|----------------|------------|
| | | | | | |

| OTHER PAYER DATE MM DD CCYY | OTHER PAYER I.D. | QUAL. (17) | OTHER PAYER REJECT CODES | USUAL & CUST. CHARGE |
|--------------------------------|------------------|------------|--------------------------|----------------------|
| | | | | |

2

2

| PRESCRIPTION / SERV. REF. # | QUAL. (8) | DATE WRITTEN MM DD CCYY | DATE OF SERVICE MM DD CCYY | FILL# | QTY DISPENSED (9) | DAYS SUPPLY |
|-----------------------------|-----------|----------------------------|-------------------------------|-------|-------------------|-------------|
| | | | | | | |

| | |
|--|----------------------------|
| | INGREDIENT COST SUBMITTED |
| | DISPENSING FEE SUBMITTED |
| | INCENTIVE AMOUNT SUBMITTED |
| | OTHER AMOUNT SUBMITTED |
| | SALES TAX SUBMITTED |
| | GROSS AMOUNT DUE SUBMITTED |
| | PATIENT PAID AMOUNT |
| | OTHER PAYER AMOUNT PAID |
| | NET AMOUNT DUE |

| PRODUCT / SERVICE I.D. | QUAL. (10) | DAW CODE | PRIOR AUTH # SUBMITTED | PA TYPE (11) | PRESCRIBER I.D. | QUAL. (12) |
|------------------------|------------|----------|------------------------|--------------|-----------------|------------|
| | | | | | | |

| DUR/PPS CODES (13) | BASIS COST (14) | PROVIDER I.D. | QUAL. (15) | DIAGNOSIS CODE | QUAL. (16) |
|--------------------|-----------------|---------------|------------|----------------|------------|
| | | | | | |

| OTHER PAYER DATE MM DD CCYY | OTHER PAYER I.D. | QUAL. (17) | OTHER PAYER REJECT CODES | USUAL & CUST. CHARGE |
|--------------------------------|------------------|------------|--------------------------|----------------------|
| | | | | |

