[redacted]

Hawaii Medical Fiscal Agent
Attention: Claims
P.O BOX 967, HENDERSON, NC 27536-0967

PRESCRIPTION DRUG CLAIM

1. Identification Number	2. Recipient's Name	3. Date of Birth	4. **Pharmacy NPI**
5. Pharmacy Name		6. Pharmacy Address	
7. Prescriber's NPI	8. Prescriber's DEA (for C II – V drugs)	9. Prescriber's Name	

10. Other Drug or Liability Coverage Yes ☐ No ☐ Name of Coverage	11. Date of Accident	12. Illness or Injury?	Work Related? Yes ☐ No ☐	Automobile? Yes ☐ No ☐	13. ICF-MR/ICF/SNF? Yes ☐ No ☐
			Third Party? Yes ☐ No ☐	Other Accident? Yes ☐ No ☐	

									Submitted Charge	Paid by TPL Amount **	TOTAL
1	14. RX Number	15. Metric Quantity	16. Billing Unit 16 ☐ Gm ☐ ML ☐Each	17. Days Supply	18. NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	19. Diagnosis Code 19	27.	28.	29.		
	20. Date	21. ☐New ☐Refill	22. Drug Name/Strength	23. DAW Code	24. Prior Authorization Number	25. Reason for Refill Too Soon Override		26. ✓ If Compound 26 ☐			
2	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	Diagnosis Code					
	Date	☐New ☐Refill	Drug Name/Strength	DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override		✓ If Compound ☐			
3	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	Diagnosis Code					
	Date	☐New ☐Refill	Drug Name/Strength	DAW Code	Prior Authorization Number.	Reason for Refill Too Soon Override		✓ If Compound ☐			
4	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	Diagnosis Code					
	Date	☐New ☐Refill	Drug Name/Strength	DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override		✓ If Compound ☐			
5	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	Diagnosis Code					
	Date	☐New ☐Refill	Drug Name/Strength	DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override		✓ If Compound ☐			
6	RX Number	Metric Quantity	Billing Unit ☐ Gm ☐ ML ☐Each	Days Supply	NDC ___ ___ ___ ___ ___/ ___ ___ ___ ___/ ___ ___	Diagnosis Code					
	Date	☐New ☐Refill	Drug Name/Strength	DAW Code	Prior Authorization Number	Reason for Refill Too Soon Override		✓ If Compound ☐			

** Attach a copy of EOB

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 false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal of State laws. I hereby agree to keep such records as are necessary to fully disclose the extent of service provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

Provider's Signature _____ Date _____

DHS 204 (02/18)