ACS
HAWAII STATE MEDICAID FEE FOR SERVICE PROGRAM
365 NORTHRIDGE RD, SUITE 400 • ATLANTA, GA 30350
PRESCRIPTION DRUG CLAIM

Identification Number [1]	Member's Name [2]	Date of Birth [3]

Pharmacy NABP [4]	Pharmacy Name [5]	Physician's Name [6]	Physician's DEA # / Provider Medicaid ID # [7]

Pharmacy Address [8]

Other Drug or Liability Coverage [9] Yes ☐ No ☐ Name of Coverage _____	Date of Accident [10]	Is the illness or injury:[11] Work Related Yes ☐ No ☐ Third Party? Yes ☐ No ☐ Automobile Yes ☐ No ☐ Other Accident? Yes ☐ No ☐	ICF-MR/ICF/SNF? [12] Yes ☐ No ☐

								Submitted Charge [25]	Paid by TPL Amount [26] (Attach a copy of EOB)	TOTAL [27]
1	RX Number [13]	Metric Qty [14]	Days Supply [15]	NDC [16] __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code [17]			
	Date [18]	☐New ☐Refill [19]		Drug Name [20]	DAW Code [21]	Prior Authorization No. [22]	Reason for Refill Too Soon Override [23]		✓ if Cmpd.[24] ☐	
2	RX Number	Metric Qty	Days Supply	NDC __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code			
	Date	☐New ☐Refill		Drug Name	DAW Code	Prior Authorization No.	Reason for Refill Too Soon Override		✓ if Cmpd. ☐	
3	RX Number	Metric Qty	Days Supply	NDC __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code			
	Date	☐New ☐Refill		Drug Name	DAW Code	Prior Authorization No.	Reason for Refill Too Soon Override		✓ if Cmpd. ☐	
4	RX Number	Metric Qty	Days Supply	NDC __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code			
	Date	☐New ☐Refill		Drug Name	DAW Code	Prior Authorization No.	Reason for Refill Too Soon Override		✓ if Cmpd. ☐	
5	RX Number	Metric Qty	Days Supply	NDC __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code			
	Date	☐New ☐Refill		Drug Name	DAW Code	Prior Authorization No.	Reason for Refill Too Soon Override		✓ if Cmpd. ☐	
6	RX Number	Metric Qty	Days Supply	NDC __ __ __ __ __ / __ __ __ __ / __ __			Diag. Code			
	Date	☐New ☐Refill		Drug Name	DAW Code	Prior Authorization No.	Reason for Refill Too Soon Override		✓ if Cmpd. ☐	

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 or 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

Use For ACS Only

Form 204 (10/02)