

PLEASE PRINT CLEARLY

Indiana Health Coverage Programs
DRUG CLAIM FORM

1 MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
RID NO. 06		PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10	DAYS SUPPLY 11	USUAL & CUSTOMARY CHARGE 12			
DATE PRESC 13	DATE DISP 14	NDC NUMBER 15		TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17	OTHER AMOUNT CLAIMED SUBMITTED 18		GROSS AMOUNT DUE 19		
2 MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
RID NO. 06		PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10	DAYS SUPPLY 11	USUAL & CUSTOMARY CHARGE 12			
DATE PRESC 13	DATE DISP 14	NDC NUMBER 15		TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17	OTHER AMOUNT CLAIMED SUBMITTED 18		GROSS AMOUNT DUE 19		
3 MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
RID NO. 06		PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10	DAYS SUPPLY 11	USUAL & CUSTOMARY CHARGE 12			
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DATE PRESC 13	DATE DISP 14	NDC NUMBER 15		TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17	OTHER AMOUNT CLAIMED SUBMITTED 18		GROSS AMOUNT DUE 19		
PROVIDER'S NAME AND ADDRESS <input type="checkbox"/> 20				<p>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 falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable federal or state laws.</p> <p>I, the undersigned, being aware of restricted funds in the IHCP Program, agree to accept as full payment for services enumerated on this claim form, for this IHCP patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.</p>							
PROVIDER NPI 21				SIGNATURE OF PROVIDER OR REPRESENTATIVE <input type="checkbox"/> 23				DATE BILLED 24			
PROVIDER TYPE <input type="checkbox"/> PHARMACY <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DENTIST <input type="checkbox"/> OTHER											
22											

MAIL COMPLETED CLAIM FORM TO:

HP Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268