

PLEASE PRINT CLEARLY

Indiana Health Coverage Programs
DRUG CLAIM FORM

1 MEMBER NAME: LAST, FIRST				PRESCRIBER NPI	EMERGENCY	PREG	PATIENT RESIDENCE	
01				02	03	04	05	
RID NO.		PRESCRIPTION NUMBER		DAW CODE	REFILL NUMBER	QUANTITY DISPENSED	DAYS SUPPLY	USUAL & CUSTOMARY CHARGE
06	07		08	09	10	11	12	
DATE PRESC	DATE DISP	NDC NUMBER		OTHER PAYER AMOUNT PAID		OTHER COVERAGE CODE	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	
13	14	15		16		17	18	
2 MEMBER NAME: LAST, FIRST				PRESCRIBER NPI	EMERGENCY	PREG	PATIENT RESIDENCE	
01				02	03	04	05	
RID NO.		PRESCRIPTION NUMBER		DAW CODE	REFILL NUMBER	QUANTITY DISPENSED	DAYS SUPPLY	USUAL & CUSTOMARY CHARGE
06	07		08	09	10	11	12	
DATE PRESC	DATE DISP	NDC NUMBER		OTHER PAYER AMOUNT PAID		OTHER COVERAGE CODE	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	
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13	14	15		16		17	18	
PROVIDER'S NAME AND ADDRESS				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.				
<input type="checkbox"/> 19				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.				
PROVIDER NPI				SIGNATURE OF PROVIDER OR REPRESENTATIVE		DATE BILLED		
20				<input type="checkbox"/> 22		23		
PROVIDER TYPE								
<input type="checkbox"/> PHARMACY								
<input type="checkbox"/> PHYSICIAN								
<input type="checkbox"/> DENTIST								
<input type="checkbox"/> OTHER								
21								

MAIL COMPLETED CLAIM FORM TO:

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