DO NOT WRITE IN SPACE BELOW

1. PHARMACY PROVIDER NO.

2. PATIENT'S NAME (LAST) FIRST NAME M.I.

ADDRESS

3. PATIENT'S NUMBER

FROM CURRENT I.D. CARD

INITIALS OF PROGRAM FOR WHICH PATIENT IS ELIGIBLE

5. OTHER THIRD PARTY LIABILITY (TO BE PAID BY OTHER PUBLIC PRIVATE PROGRAMS).

4. CHECK APPROPRIATE BOX IF PATIENT IS IN AN IN-PATIENT FACILITY

[1] SKILLED NURSING FACILITY

[2] INTERMEDIATE CARE FACILITY

[3] BOARDING HOME

6. RX INFORMATION

												DOLLARS	CENTS
1	RX NUMBER	O/R	PRESCRIBER DEA/BNDD NUMBER	PRESCRIBER NAME			DATE PRESCRIBED MO. DAY YR.	DATE FILLED MO. DAY YR.	QTY.	EST. DAYS SUPPLY			
	P.A. # OR S/O.M.	MN	DRUG NAME AND STRENGTH INCL. DOSAGE FORM	MFG.	NDC				OTHER COVERAGE		TOTAL BILLED		
2	RX NUMBER	O/R	PRESCRIBER DEA/BNDD NUMBER	PRESCRIBER NAME			DATE PRESCRIBED MO. DAY YR.	DATE FILLED MO. DAY YR.	QTY.	EST. DAYS SUPPLY			
	P.A. # OR S/O.M.	MN	DRUG NAME AND STRENGTH INCL. DOSAGE FORM	MFG.	NDC				OTHER COVERAGE		TOTAL BILLED		
3	RX NUMBER	O/R	PRESCRIBER DEA/BNDD NUMBER	PRESCRIBER NAME			DATE PRESCRIBED MO. DAY YR.	DATE FILLED MO. DAY YR.	QTY.	EST. DAYS SUPPLY			
	P.A. # OR S/O.M.	MN	DRUG NAME AND STRENGTH INCL. DOSAGE FORM	MFG.	NDC				OTHER COVERAGE		TOTAL BILLED		
4	RX NUMBER	O/R	PRESCRIBER DEA/BNDD NUMBER	PRESCRIBER NAME			DATE PRESCRIBED MO. DAY YR.	DATE FILLED MO. DAY YR.	QTY.	EST. DAYS SUPPLY			
	P.A. # OR S/O.M.	MN	DRUG NAME AND STRENGTH INCL. DOSAGE FORM	MFG.	NDC				OTHER COVERAGE		TOTAL BILLED		

7. COMPOUNDED PRESCRIPTION INFORMATION (NAME OF INGREDIENT, AMT. & COST)

MEDICAID RECIPIENT BENEFITS ASSIGNED TO STATE OF MAINE BY LAW

MAIL TO: MEDICAL ASSISTANCE CLAIMS PROCESSING
M-1200
AUGUSTA, MAINE 04330

X

8. PROVIDER SIGNATURE

I CERTIFY THAT THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

9. DATE

BMS-012 (10/81)