I.D. 000999999 GROUP I.D.

CARDHOLDER NAME PLAN NAME

PATIENT NAME Doe, Jane OTHER COVERAGE CODE (1) PERSON CODE (2)

PATIENT DATE OF BIRTH MM DD CCYY PATIENT (3) GENDER CODE PATIENT (4) RELATIONSHIP CODE

PHARMACY NAME Anytown Pharmacy

ADDRESS 222 Jefferson St SERVICE PROVIDER I.D. QUAL (5)

CITY Anytown PHONE NO. ( )

STATE & ZIP CODE SD 57999 FAX NO. ( )

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION

EMPLOYER NAME

ADDRESS

CITY **STATE** **ZIP CODE**

CARRIER I.D. (6) **EMPLOYER PHONE NO.**

DATE OF INJURY MM DD CCYY **CLAIM (7) REFERENCE I.D.**

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM	DD	CCYY	DATE OF SERVICE MM	DD	CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
999999					01	01	2005		12	30

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)
00001-0001-01					5600000 or Smith	

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
				99.99

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
89.99	* OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2 * - When Applicable

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM	DD	CCYY	DATE OF SERVICE MM	DD	CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

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