DATE: ___/___/____
MM DD YYYY

STATE OF _____
_____ (Medicaid Agency)

PAGE ___ OF ____

Source: State Agencies
Target: Manufacturers

MEDICAID DRUG REBATE INVOICE

Manufacturer: _____
Address: _____
City: _____ State: ___ Zip: _____

STATE CODE: ____ INVOICE NO.: _____
PERIOD COVERED:_____(QYYYY)

NDC Number	Drug Name	Unit Rebate Amount	Units Reimbursed	Rebate Amount Claimed	No. of Scripts	Medicaid Amount Reimbursed	Non-Medicaid Amount Reimbursed	Total Amount Reimbursed	Correction Flag
		TOTALS:							

*Please remit this amount to: _____ (Medicaid Agency)
Address:
Attn:

Form CMS-R-144 (Exp. 07/31/09)
OMB No. 0938-0582