DATE: ___/___/____ STATE OF _____ PAGE ___ OF ____
MM DD YYYY _____ (Medicaid Agency)

Source: State Agencies
Target: Manufacturers

MEDICAID DRUG REBATE INVOICE

Manufacturer: _____ STATE CODE: ____ INVOICE NO.: _____
Address: _____ PERIOD COVERED:_____(QYYYY)
City: _____ State: ____ Zip: _____

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