	TE://_ STATE OF MM DD YYYY			F PAGE OF (Medicaid Agency)						
Source: Stat Target: Mai			М	EDICAID DRU	JG REBATE	INVOICE				
Manufacturer Address:	:: State: Zip:			STATE CODE: INVOICE NO.: PERIOD COVERED:(QYYYY)						
NDC Number	Drug Name	Unit Rebate Amount	Record ID	_ Units Reimbursed	Rebate Amount Claimed	No. of Scripts	Medicaid Amount Reimbursed	Non- Medicaid Amount Reimbursed	Total Amount Reimbursed	Correction Flag
		TOTALS:		*DI						
				*Please ren Address: Attn:	nit this amoun	t to:			(Medicaid Ag	ency)

Form CMS-R-144 OMB No. 0938-0582