DATE: /_/ MM DD YYYY			STATE O	F		PAGE(Medicaid Agency)				
Source: Stat Target: Mar			\mathbf{M}	EDICAID DRU	G 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 Reimburs ed	Correction Flag
		TOTALS:								
				*Please rem Address: Attn:	nit this amoun	t to:			(Medicaid A	gency)

CMS-R-144 (Exp. TBD) OMB No. 0938-0582

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0582. The time required to complete this information collection is estimated to average 46 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.