

DATE: ____/____/____
MM DD YYYY

STATE OF _____ PAGE ____ OF ____

(Medicaid Agency)

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	Record ID	Units Reimbursed	Rebate Amount Claimed	No. of Scripts	Medicaid Amount Reimbursed	Non-Medicaid Amount Reimbursed	Total Amount Reimbursed	Correction Flag
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

TOTALS:

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

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