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	Record ID	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:

CMS-R-144 (Exp. 07/31/2020)
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.