**MEDICAID DRUG REBATE INVOICE**

DATE: / / STATE OF PAGE OF \_\_\_\_

MM DD YYYY

(Medicaid Agency)

Source: State Agencies

Target: Manufacturers

Manufacturer: STATE CODE: INVOICE NO.: \_\_\_\_\_

Address: PERIOD COVERED: \_\_\_\_\_\_\_(QYYYY)

City: State: Zip: \_\_\_\_\_\_

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| **NDC Number** |  | **FDA Product**  **Name** |  | **Unit Rebate Amount** |  | **Record ID** |  | **Units Reimbursed** |  | **Rebate Amount Claimed** |  | **Number of Prescriptions** |  | **Medicaid Amount Reimbursed** |  | **Non-Medicaid Amount Reimbursed** |  | **Total Amount Reimbursed** |  | **Filler** | |
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|  |  |  |  | TOTALS: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | | |

\*Please remit this amount to: (Medicaid Agency)

Address:

Attn: