

Pharmacy Statement (525-106)

Print Or Type All Information

Fax to: 360-507-9074

INTERNAL CONTROL NUMBER (HCA USE ONLY)

PROVIDER NAME AND ADDRESS NPI NUMBER	PATIENT NAME AND ADDRESS
REQUESTING PROVIDER FAX NUMBER	PROVIDER ONE CLIENT IDENTIFICATION NUMBER

Detail Claim Information

1.							
PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME <input type="checkbox"/> Yes <input type="checkbox"/> NO	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME			PAYABLE BY PATIENT		
PRESCRIBER'S NPI	PRESCRIPTION (DIRECTIONS FOR USE)			AUTHORIZATION NUMBER		INSURANCE PAID AMOUNT	
GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No	JUSTIFICATION/COMMENTS					BALANCE DUE	

2.							
PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME <input type="checkbox"/> Yes <input type="checkbox"/> NO	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME			PAYABLE BY PATIENT		
PRESCRIBER'S NPI	PRESCRIPTION (DIRECTIONS FOR USE)			AUTHORIZATION NUMBER		INSURANCE PAID AMOUNT	
GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No	JUSTIFICATION/COMMENTS					BALANCE DUE	

3. Compound Prescriptions – Limit 1 Compound Prescription Per Claim Form: (ALL BELOW FIELDS REQUIRED)			
NAME	NDC	QUANTITY	COST

<p align="center">PROVIDER CERTIFICATION</p> <p>I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, and that the foregoing information is true, accurate and complete</p>	<p>NET TOTAL BILLED</p>
SIGNATURE OF PHARMACIST (IN INK)	DATE