NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1A 2402
1B 2402

1. PROVIDER ID NUMBER	2. DATE FILLED MO DAY YR		3. SA EXCP. CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: 4. CODE (A V)	4A. ORIGINAL CLAIM REFERENCE NUMBER

5. RECIPIENT ID NUMBER	6. DATE OF BIRTH (M M D D Y Y Y Y)	7. SEX (M 1 / F 2)	8. RECIPIENT OTHER INSURANCE CODE	9. RECIPIENT NAME LAST FIRST

10. PROF CD	10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	10B. NAME	PRIOR APPROVAL/AUTHORIZATION NO.	L I N E	FOR OFFICE USE ONLY
11. PROF CD	11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	11B. NAME	12. / 13.	12A. / 13A.	14. 1

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO. DAY YR.	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW/ REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY (Y 1 / N)	22. AMOUNT CHARGED	MEDICARE 23. CO INSURANCE	23A. DEDUCTIBLE	23B. CO PAY	23C. PAID	24. OTHER INSURANCE PAID
1								Y 1 N						
2								Y 1 N						
3								Y 1 N						
4								Y 1 N						
5								Y 1 N						
				25. CASE MGR. I.D.	TOTALS ▶				26.	27.	27A.	27B.	27C.	28.

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE	30. COUNTY*	31. BILLING DATE MO. DAY YR.

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA

EMEDNY - 000301 (01/04) 1-11-0071 (12/03)

FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	
	COMPOUNDING FEE	
	DISPENSING FEE	
	AMOUNT CHARGED	$

8908-2402-3210

(PERF)

(PERF)

FACE SCREENING 20% & 30%

(PERF)

CERTIFICATION

Individual Provider:
Provider certifies that: I am a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; I have reviewed this form; I have furnished the care, services and supplies itemized in accordance with applicable federal state laws and regulations. I certify that the services were rendered at the location listed in the ''place of service'' field. **I have read the Medicaid Management Information Systems Provider Manual as it relates to this claim form, and all revisions and updates thereto; all claims are made in full compliance with the pertinent provisions of the Manual, revisions and updates; all claims for care services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the Manual, revisions, or updates. All care, services, and supplies for which claim is made are medically necessary for the treatment of the named recipient.**

Entities:
(Person authorized to certify for the group) certifies that the person identified as the service provider listed in the field on the front of this form is a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; I have reviewed this form; I certify that the service provider furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations. I certify that the services were rendered at the location listed in the ''place of service'' field. **I have read the Medicaid Management Information Systems Provider Manual as it relates to this claim form, and all revisions and updates thereto; all claims are made in full compliance with the pertinent provisions of the Manual, revisions and updates; all claims for care services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the Manual, revisions, or updates. All care, services, and supplies for which claim is made are medically necessary for the treatment of the named recipient.**

All:
The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefor shall be promptly furnished upon request to the local or State Departments of Social Services, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirements of 42CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing, subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Social Services as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

(PERF)