

DO NOT WRITE IN SPACE BELOW

1. PHARMACY PROVIDER NO.

2. PATIENT'S NAME (LAST) FIRST NAME M.I.

ADDRESS

5. OTHER THIRD PARTY LIABILITY (TO BE PAID BY OTHER PUBLIC PRIVATE PROGRAMS).

3. PATIENT'S NUMBER

INITIALS OF PROGRAM FOR WHICH PATIENT IS ELIGIBLE

FROM CURRENT I.D. CARD

4. CHECK APPROPRIATE BOX IF PATIENT IS IN AN IN-PATIENT FACILITY

1 SKILLED NURSING FACILITY

2 INTERMEDIATE CARE FACILITY

3 BOARDING HOME

6. RX INFORMATION		7. COMPOUNDED PRESCRIPTION INFORMATION (NAME OF INGREDIENT, AMT. & COST)		4. CHECK APPROPRIATE BOX IF PATIENT IS IN AN IN-PATIENT FACILITY		5. OTHER THIRD PARTY LIABILITY (TO BE PAID BY OTHER PUBLIC PRIVATE PROGRAMS)		9. DATE		
RX NUMBER	P.A. # OR S.O.M.	MAN DRUG NAME AND STRENGTH INCL. DOSAGE FORM	OR	PREScriBER DEARNDU NUMBER	PREScriBER NAME	DATE PRESCRIBED MO. DAY YR.	DATE FILLED MO. DAY YR.	QTY.	EST. DAYS SUPPLY	TOTAL BILLED
1										
2										
3										
4										

MEDICAID RECIPIENT
BENEFITS ASSIGNED TO
STATE OF MAINE
BY LAW

MAIL TO: MEDICAL ASSISTANCE CLAIMS PROCESSING
M-1200
AUGUSTA, MAINE 04330

8. PROVIDER SIGNATURE
I CERTIFY THAT THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

BMS-012 (10/81)