STATE OF MONTANA – DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PLEASE TYPE OR PRINT

FOR USE BY PHARMACIES Return form to: **FORM NO. MA-5**

Claims Processing Unit, Dept. MA-5, P.O. Box 8000, Helena, MT 59604

Telephone 1-800-624-3958 or 406-442-1837

SECTION I – PROVIDER INFORMATION

1. Name – Provider	2. NPI
3. Address – Provider (Street, City, State, Zip Code)	4. ◯ MHSP ◯ Medicaid

SECTION II – RECIPIENT INFORMATION

5. Cardholder Identification Number – Recipient	6. Name – Recipient (Last, First, Middle Initial)	7. Date of Birth – Recipient

SECTION III – CLAIM INFORMATION

8. Prescriber Number	9. Prescription Type Electronic	10. Date Filled	11. Refill	12. Compound ◯ Yes ◯ No
13. NDC	14. Days' Supply	15. Quantity	16. Charge $	17. Unit Dose ◯ Yes ◯ No
18. Prescription Number	19. DAW	20. Drug Description	21. Level of Effort	22. Sub Clar Code
23. Other Coverage Code	24. Total Charges $	25. Other Coverage Amount $	26. Patient Paid $	27. Net Billed $

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29. Certification – I certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the services(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to Title XIX of the Social Security Act, Montana Statues and the Administrative Rules of Montana.		TOTAL CHARGES	$
		AMOUNT TO BE PAID BY MEDICAID	$
Signature – Pharmacist or Dispensing Physician	Date Signed	AMOUNT TO BE PAID BY RECIPIENT	$