DATE: ___/___/_____ STATE OF _____ PAGE ___ OF ___
MM DD YYYY _____ (Medicaid Agency)

Source: State Agencies
Target: Manufacturers

MEDICAID DRUG REBATE INVOICE

Manufacturer: _____ STATE CODE: ___ INVOICE NO.:
Address: _____ PERIOD COVERED: _____ (QYYYY)

City: _____ State: _____ Zip: _____

NDC Number	Drug Name	Unit Rebate Amount	Units Reimbursed	Rebate Amount Claimed	No. of Scripts	Medicaid Amount Reimbursed	Non-Medicaid Amount Reimbursed	Total Amount Reimbursed	Correction. Flag
		TOTALS:							

Note: NDC# = Labeler Code (5#s)
Product Code (4#s)
Pkg. Size Codes (2#s)

*Please remit this amount to: _____ (Medicaid Agency)
Address:

Form CMS-R-144 (Exp. 07/31/09)
OMB No. 0938-0582