Mail Claims To:
P.O. Box 3781
Little Rock, AR 72203

ARKANSAS KIDNEY DISEASE COMMISSION

Prescription Drug Claim Form

Fax Claims To:
Fax: (501) 686-2831
Tel: (501) 686-2807

Vendor Number: _____ Tel: ( )
Vendor Name _____
Address: _____
City, State, Zip: _____

Patient SSN: _____
Patient Name: _____
Address: _____
City, State, Zip: _____

Please complete a separate form for each patient per month. Please list your vendor number and the patient's social security number on the form. *Incomplete or incorrect forms may be returned for correction*. Please allow 6 to 8 weeks for processing. Thank you.

Date	Rx#	Qty./Dsg.	Drug Description/Name	Nature of Illness	Prescribing MD	Retail Amount

Total retail amount **$** _____
Total amount allowed **$** _____
Total paid by Medicare **(** _____ **)**
Total paid by Medicaid **(** _____ **)**
Total paid by Private Insurance **(** _____ **)**
Total paid by AKDC client co-pay ($2.00 each Rx) **(** _____ **)**
TOTAL CHARGED TO THE AKDC **$** _____

(THERE IS A MAXIMUM OF THREE (3) PRESCRIPTIONS PER MONTH; ONE MONTH PER SHEET)

I certify that the above drugs and medicines were necessary for the treatment of the illness/injury reported, and that all charges listed are correct and net of applicable credits and co-payments.

Pharmacist Signature _____ **Date** _____