Arkansas Kidney Disease Commission

4815 W. Markham St. Slot 35 | Tel: 501-686-2807 | Fax: 501-686-2831

Prescription Drug Claim Form

Patient Information:				
First Name	*Last Name*	*Social Security Number*		
Address	*City*		*State* AR	*Zip Code*

Vendor Information:						
Vendor Number	*Vendor Name*	*Vendor's Email*				
Address	*City*	*State* AR	*Zip Code*	*Phone*	*Fax*	

Please complete a separate form for each patient per month. *Incomplete or incorrect forms may be denied and/or 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 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 supplies were necessary for the treatment of the illness reported, and that all charges listed are correct and net of applicable credits and co-payments.

______________________________ ______________________________

Pharmacist Signature *Date*

Revised: May 2018