	TE://_ STATE OF			PAGE OF (Medicaid Agency)						
Source: Stat Target: Mai			M	EDICAID DRU	JG REBATE	INVOICE				
Manufacturer Address:	:: State: Zip:			STATE CODE: INVOICE NO.: PERIOD COVERED:(QYYYY)						
NDC Number	Drug Name	Unit Rebate Amount	Record ID	- Units Reimbursed	Rebate Amount Claimed	No. of Scripts	Medicaid Amount Reimbursed	Non- Medicaid Amount Reimbursed	Total Amount Reimbursed	Correction Flag
		TOTALS:		*Please rer	nit this amoun	t to:			(Medicaid Ag	ency)
				Address: Attn:	int tins amoun				(Wedleard / Ig	chey)

Form CMS-R-144 (Exp. 11/30/14) OMB No. 0938-0582